PDO THREAD LIFT
Consultation

Last Name:________________First Name:________________Date of Birth(D.O.B):__________
Your Address:____
Doctors Name and Number:____
How Were You Referred To Our facility:____
Allergies To Any Medications Or Foods:____
Current Medications:____
Previous Surgeries:____
Email:_______________________________________Phone:________________________

HAVE YOU USED OR HAVE YOU HAD ANY OF THE FOLLOWING: *(please check)*

- Accutane
- Retin-A-Burns
- Dye Laser
- Chemical Peel
- Grafts
- Glycolic Acid
- Laser Resurfacing
- Sunburn
- Photo-Derm
- Intense Light

If you checked any, when and which area:____

DO YOU HAVE ANY OF THE FOLLOWING: *(please check)*

- In Menopause
- Post Menopause
- Regular Periods
- Hormone Imbalance
- Bleeding Disorder
- Pacemaker
- Hypoglycemia
- Pregnant
- Breast Feeding
- Herpes
- Hepatitis C
- Contact Lenses
- Epilepsy
- HIV/AIDS
- Cancer
- Depression
- Hemophilia
- Cold Sores
- Mental Illness
- High Blood Pressure
- Heart Condition
- Keloid Scars
- Dermatitis/Eczema
- Latex Allergy

I acknowledge that all the above information contributed by me is true and accurate to the best of my knowledge.

Signature:____**Date:**________