bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

Name: _____
Today's Date:_____
Date of birth: _____
Gender: Male Female
Address: _____
_____
Phone Number: Home: _____
Social Security #: _____
Cellular/Other: _____
Next of Kin: _____
Occupation: _____
Referred by: Friend/Family Print Ad Internet
Other_____
Reason for Visit: _____
Email Address: _____
Please take a few moments to answer the following questions:

What is your: Height: _____ Weight: _____

Do you have any ***allergies*** to any type of medication? Yes/No
If yes, which ones? _____
Are you taking any ***prescription medications***? Yes/No
If yes, which ones?_____
Are you a ***smoker***? Yes/No
If female, is there any chance that you could be ***pregnant***? Yes/No
Have you taken ***aspirin*** within the last week? Yes/No
Do you regularly take any ***herbal products***? Yes/No

List any ***medical problems*** or conditions that you may have below: None
_____
List any ***surgical procedures*** you have had done below: None
_____

Are you interested in financing? Yes/No

"You will be expected to complete this form prior to your pre-operative examination by one of our surgeons."