CHUA PLASTIC SURGERY

Statement of Non-Solicitation

I, _____(patient name) hereby state that I came to Chua Plastic Surgery of my own free will and volition. Neither Dr. Charleston Chua, nor anyone employed by Chua Plastic Surgery, solicited, marketed, induced, contacted, or otherwise reached out to me by any means prior to my initial contact and consultation with Chua Plastic Surgery on _____(date). I was a patient of Dr. Charleston Chua prior to this initial consultation at a different surgical practice. Notwithstanding my prior patronage of that other surgical practice, I chose to exercise my free will and seek out Dr. Charleston Chua at Chua Plastic Surgery to perform my requested procedure(s). I further attest that I was not asked, coerced, or paid by any person, company, or associate thereof to seek out Dr. Charleston Chua at Chua Plastic Surgery for the purpose of reporting information back about the practice.

_____ _____

Patient or Person Authorized to Sign for Patient Date

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Consultation Form

(Shaded areas are for office use only)

Name:_____ Date of birth:_____ Age:_____ Gender: M / F

Street address: _____ City: _____ State: _____ Zip: _____

Phone number:_____ Email address:_____

Height: _____ Weight: _____ Occupation: _____

Emergency contact: _____ Emergency contact phone number: _____

Primary care doctor: _____ Last time you saw this doctor: _____

Reason For Consultation Around what date were you thinking about getting this surgery? _____	☐ Abdominoplasty (Tummy tuck)	☐ Brazilian Butt Lift
	☐ Breast Augmentation	☐ Breast Lift
	☐ Liposuction (which areas) _____	☐ Other: _____

Past Medical History - Have you had or currently have any of the following:

High blood pressure	▢ Yes ▢ No	Von Willebrand	▢ Yes ▢ No	Kidney problems	▢ Yes ▢ No
High cholesterol	▢ Yes ▢ No	Factor V Leiden	▢ Yes ▢ No	Liver problems	▢ Yes ▢ No
Asthma	▢ Yes ▢ No	G6PD Deficiency	▢ Yes ▢ No	Hepatitis	▢ Yes ▢ No
Diabetes Type 1	▢ Yes ▢ No	Sickle Cell Disease	▢ Yes ▢ No	Chlamydia	▢ Yes ▢ No
Diabetes Type 2	▢ Yes ▢ No	Sickle Cell Trait	▢ Yes ▢ No	Gonorrhea	▢ Yes ▢ No
Heart disease	▢ Yes ▢ No	Pulmonary Embolism	▢ Yes ▢ No	HIV/AIDS	▢ Yes ▢ No
Anemia	▢ Yes ▢ No	Deep Vein Thrombosis	▢ Yes ▢ No	Stomach problems	▢ Yes ▢ No
COPD	▢ Yes ▢ No	Wolff Parkinson White	▢ Yes ▢ No	Chronic pain	▢ Yes ▢ No
Cancer	▢ Yes ▢ No	Clotting Problems	▢ Yes ▢ No	Heart attack/stroke	▢ Yes ▢ No
Heart failure	▢ Yes ▢ No	Malignant Hyperthermia	▢ Yes ▢ No	Psychiatric Problems	▢ Yes ▢ No

Women Only:

Are you pregnant or might be pregnant?	▢ Yes ▢ No				How much/often?
			Nicotine	▢ Yes ▢ No	
Are you nursing?	▢ Yes ▢ No		Alcohol	▢ Yes ▢ No	
Are you taking any form of birth control?	▢ Yes ▢ No		Recreational Drugs	▢ Yes ▢ No	

Social History

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Family History (please list all diseases that run in the family or rare disease someone has been diagnosed with):

_____

Have you or anyone in your family had issues with anesthesia? ▢ Yes ▢ No

Past Surgical History (Please list all surgeries you've had whether necessary or elective):

_____

_____

Medications	Vitamins/Supplements	Specific Allergies		If "Yes", what is the reaction?
		Latex	▢ Yes ▢ No	
		Penicillin	▢ Yes ▢ No	
		Sulfa	▢ Yes ▢ No	
		Iodine	▢ Yes ▢ No	
		Other		

Measured Height _____ Measured Weight _____	Calculated BMI _____
Itemized Procedure Requested	Itemized Quote Given
	Discounts/Specials:
	Total Quote:
Surgery Date Requested:	Doctor Consultation Date:
Special Notes:	
▢ Medical clearance ▢ Labs ▢ Photos ▢ Consultation Fee	
Initial Consult By:	