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### INITIAL VISIT QUESTIONNAIRE

Thank you for choosing to come to our office. Please fill out the following information. We know it is a lot of paperwork, but this knowledge allows us to design a personalized treatment plan customized for you. If you don't know an answer, leave it blank and ask us to help. These facts will be kept extremely confidential. Please print clearly. So, let's begin.....

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

I like to be addressed as \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail Address \_\_\_\_\_

May we send information to your home?  Yes  No E-mail?  Yes  No

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_ Emergency (\_\_\_\_\_) \_\_\_\_\_

Name of Emergency Contact Person \_\_\_\_\_

Relationship \_\_\_\_\_

May we call you at home to verify appointments?  Yes  No

If not, what is the best way to reach you? \_\_\_\_\_

Occupation \_\_\_\_\_

Married  Partnered  Single  Widowed  Divorced  Separated

How did you learn about us? \_\_\_\_\_

Being here makes me feel  Nervous  Excited  Scared  Guilty  Happy

Hopeful  Empowered  Shy  Other \_\_\_\_\_

Do you participate in sports or aerobic activities?  NO  YES which ones? \_\_\_\_\_

**My Medical History:**

ALLERGIES: \_\_\_\_\_ WT \_\_\_\_\_ HT \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Who is your family or regular physician? \_\_\_\_\_

Address or phone number: \_\_\_\_\_

Would you like us to call your physician to discuss your treatments with us?  NO  YES

Would you like us to send your physician a copy of the op reports, photos and or other information?

NO  YES

Do you have or have you had in the past any problems taking any medications?

NO  YES which ones? Please explain \_\_\_\_\_

**Current Medications & Vitamins/Supplements**

- 1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

**Female only: Are you currently pregnant, breastfeeding, or planning on becoming pregnant?**

- NO  YES

**Do you take Aspirin, Coumadin, Excedrin, Motrin or anything which thins your blood?**

- NO  YES which one? \_\_\_\_\_

**Current Medical Problems**

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

**Do you get cold sores?**  NO  YES

**Past Surgeries:** \_\_\_\_\_

**Blood Transfusions:**  NO  YES

**Overnight Stays in Hospital for:** \_\_\_\_\_

**Do you have any contagious diseases now or in the past (Hepatitis, AIDS, HIV, STD's, etc.)**

- NO  YES which ones?

**Have you ever been exposed to a contagious disease?**  NO  YES which ones?

**Have you been treated for any depression, emotional or psychiatric problems?**

- NO  YES

**Have you ever been in recovery or been addicted to any substance?**

- NO  YES which ones?

**Do you smoke?**  NO  YES **Do you want to stop?**  NO  YES

**Do you have any bleeding problems?**  NO  YES which ones?

**Do you have any kidney, liver, heart, thyroid, diabetes, circulation, metabolic, blood pressure, or any other diseases or problems?**  NO  YES which ones?

**Cosmetic History:**

**Have you ever had a bad reaction with a skin product?**  NO  YES which ones?

**Have you ever had liposuction before?**

- NO  YES which areas \_\_\_\_\_

**Have you had plastic or reconstructive surgery before?**

- NO  YES which type of surgery?

My current Cosmetic Doctor or Provider is \_\_\_\_\_

I have used Botox before  NO  YES

When was your last injection? \_\_\_\_\_

Any problems? \_\_\_\_\_

I have used wrinkle filler before  NO  YES

Which ones? \_\_\_\_\_

What areas were filled? \_\_\_\_\_

Any problems? \_\_\_\_\_

I had Laser Treatments before  NO  YES

Which ones? \_\_\_\_\_

Any problems? \_\_\_\_\_

I have had other cosmetic treatments such as \_\_\_\_\_

I have had esthetic skin care treatments before (e.g. Facials, Microderm abrasio, etc.)  NO  YES

Which ones? \_\_\_\_\_

I have a skin care routine  NO  YES Products used \_\_\_\_\_

**SmartLipo Areas you are considering:**

- |  |  |
|--|--|
| 1. <input type="checkbox"/> Abdomen      | 6. <input type="checkbox"/> Flanks       |
| 2. <input type="checkbox"/> Arms         | 7. <input type="checkbox"/> Knees        |
| 3. <input type="checkbox"/> Bra Overhang | 8. <input type="checkbox"/> Love Handles |
| 4. <input type="checkbox"/> Saddle Bags  | 9. <input type="checkbox"/> Thighs       |
| 5. <input type="checkbox"/> Chin/Neck    |  |

How much improvement in contouring and body change are you expecting?

- 100%     80% - 90%     60% - 70%     40% - 50%     20% - 30 %

Would you like us to call your physician to discuss or notify your intention of have SamrtLipo done?

- NO     YES

Would you like us to send your physician a copy of the op-report, photos and chart information?

- NO     YES

Do you have or have you had in the past any problems taking any medication?

- NO     YES which ones? \_\_\_\_\_

Thank you for filling out the questionnaire and congratulations! We know it is difficult to make the decision to do something just for you. But remember, it really is 'all about you'. We are excited to begin helping you 'feel fabulous at any age!'

Signature \_\_\_\_\_ Date \_\_\_\_\_