LIPOGENICS®
LASER BODY CONTOURING SYSTEM

ELIGIBILITY RECORD		
Name	**Work Phone**	
Address	**Mobile Phone**	
	E-mail	
	Birth Date	**Age**
Spouse Name	**Weight**	**Height**

How Did You Hear About LipoGenics®?

Medical Questionnaire			
			Comments
Pregnant, Breast Feeding or Currently Menstruating	YES	NO	
Have You Had Natural Child Birth in the Last 3 Months	YES	NO	
Have You Had Cesarean Child Birth in the Last 6 Months	YES	NO	
Hypertension	YES	NO	
Epilepsy	YES	NO	
Cancer	YES	NO	
Diabetes	YES	NO	
Heart Disease	YES	NO	
Skin Disease	YES	NO	
Severe Varicose Veins	YES	NO	
Infectious, Disease, Acute Disease or Fever	YES	NO	
Hemorrhagic Disease or Vascular Rupture	YES	NO	
Skin Inflammation or Skin Disease	YES	NO	
Leukemia or Hemophilia	YES	NO	
HIV or AIDS	YES	NO	
Overly Sensitive Skin	YES	NO	
Implanted Electronic Device (Pacemaker, Artificial Heart, Hearing Aids)	YES	NO	
Surgery in The Last 4 Months	YES	NO	
Do You Have Scar Damaged Tissue	YES	NO	
Are You Taking Any Photosensitive Medications	YES	NO	

List All Medical Conditions Not Listed Above you Are Experiencing

List All Medications, Vitamins, Minerals and or Supplements Currently Prescribed and Taking

Doctor's Name	**Doctor's Phone Number**

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ELIGIBILITY RECORD
Lifestyle Questionnaire

	Comments		
Job Title and Description			
Date of Last Period			
Date of Last Doctor Visit			
How Many Meals Per Day Do You Eat			
Do You Eat Regular Meals	YES	NO	
Do You Eat Fast Food	YES	NO	
Do You Exercise (List Frequency and Type in Comments)	YES	NO	
Do You Suffer from Allergies	YES	NO	
Can Your Lifestyle Be Described As High Stress	YES	NO	
Do You Smoke (List Amount in Comments)	YES	NO	
Do You Drink Alcohol (List Amount in Comments)	YES	NO	

Weight Questionnaire

	Comments
How Much Weight Are You Interested in Losing	
How Long Have You Had Your Excess Weight	
Why Are You Interested in Losing Your Excess Weight	
Do You Have An Upcoming Special Event in Your Life	
What Body Areas Do You Want to Target With LipoGenics®	
Do Any of Your Family Members Have Excess Weight	

To the best of my knowledge, this medical and lifestyle information form
presents an accurate and complete listing of my health condition and or problems.

Signature	**Date**

Approved For Treatment	YES	NO	**Comments**
Staff Name			
Staff Signature			

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