

Fat Dissolving consultation form

Client Name: _____

Date of Birth: _____ Age: _____

Address: _____

Contact Number: _____

Email: _____

Emergency Contact: _____ Phone: _____

Medical History

Please tick Yes (✓) or No (X)

Condition Yes /

No

Details (if

Yes)

Pregnant or breastfeeding

Allergies (e.g. to lidocaine, deoxycholic acid, soya, phosphatidylcholine)

Diabetes

Heart disease / high blood pressure

Liver or kidney problems

Autoimmune or inflammatory disorders

Blood disorders / on blood-thinning medication

Active skin infection at treatment site

History of keloid scarring

Previous cosmetic procedures in treatment area

Any other medical conditions

Lifestyle Information

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Question Answer

Are you currently taking any medication or supplements?

Do you smoke or vape? ☐ Yes ☐ No

Do you drink alcohol regularly? ☐ Yes ☐ No

Have you had any recent illness or surgery? ☐ Yes ☐ No

Treatment Area(s)

☐ Chin / Jawline

☐ Abdomen

☐ Flanks ("Love handles")

- ☐ Thighs
- ☐ Arms
- ☐ Other: _____

Practitioner Notes

(BMI, assessment of fat type, treatment suitability, number of sessions required)

Risks & Aftercare Discussed

- ☐ Swelling, redness, bruising, tenderness
- ☐ Temporary numbness or firmness
- ☐ Risk of infection or uneven results
- ☐ Importance of hydration and aftercare
- ☐ Results are gradual over several weeks

Client Declaration

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I confirm that I have provided full and accurate information regarding my medical history and

understand the procedure, possible risks, and aftercare instructions. I consent to receiving

fat dissolving injections and understand that results vary between individuals.

Client Signature: _____ Date: _____

Practitioner Name: _____ Signature: _____

Clinic Name: _____ Date: _____