

Brisbane Aesthetic and Plastic Surgery Centre

Dr Eddie Cheng MBBS(Qld) FRACS(Plast)

Plastic and Reconstructive Surgeon

Provider No. 2243228L

Patient Information – Consultation

Contact details

title Ms Miss Mrs Mr

first name _____

middle name/initial _____

surname _____

date of birth ____ / ____ / ____

address details

no. & street		_____	
suburb		_____	
state		_____	post code _____

contact details

home		_____	<input type="checkbox"/> answering machine
work		_____	<input type="checkbox"/> leave a message at work
mobile		_____	<input type="checkbox"/> message bank <input type="checkbox"/> sms text
email		_____	<input type="checkbox"/> inbox

how were you referred to Dr Cheng?

- friend _____ doctor _____
 word of mouth staff member _____
 advertisement in _____ Dr referral _____
 other (Please Specify) _____

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medical health

do you have any allergies? *

yes no

describe _____

*see NOTE

are you pregnant? *

yes no

are you intending to become pregnant?*

yes no

describe _____

*see NOTE

do you have any other pre-existing or current medical conditions?*

yes no

describe _____

*see NOTE

***NOTE:** if your situation or medical condition ever changes in future please ensure you advise us prior to treatments

Botox treatment

What area would you like to be treated with Botox? (please tick Yes or No)

Crow's feet	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Frown lines	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Forehead wrinkles	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Bunny lines	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Nasal tip elevation	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Botox brow lift	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Neck bands	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Marionette line	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Lip	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Gummy smile	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Dimpled chin	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Masseter/square face	<input type="checkbox"/> no	<input type="checkbox"/> yes	