



Esthétique Travel

MEDICAL FILE

In order for us to give you the best possible service,
we ask you kindly to fill out this form.

Personal data:

Miss Mrs Mr

Name:
First name:
Date of birth:
Profession:

Contact:

Address:
Postal code:
City:
Country:

Telephone:
Fax:
Mobile phone:
E-mail:

Do you have a Skype/MSN user account Yes No

If yes, please state your username:

.....

At what time will it suit you best that our medical advisor contacts you? :

.....

Medical data:

General information

Age:
Height:
Weight:

Do you smoke ? Yes No

- If yes, please state how many cigarettes per day:

- For how long have you been smoking?

Any particular medical history running in the family (breast cancer in the case of breast surgery) Yes No

- If yes, please state all relevant details:

.....

Your surgery

Please choose from the list below the type of surgery you would like to benefit from :



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FACE

1. Refractive surgery (Eximer laser)

Aesthetic medicine

2. Botox
3. Filler implants (philtrum, lips, cheeks)
4. Mesolift

Eyelid surgery

5. Eyelid lift: 2 eyelids
6. Eyelid lift: 4 eyelids

Nose surgery

7. Rhinoplastic surgery

Face lift surgery

8. Complete face lift
9. Face lift + neck

Dental surgery

10. Whitening of teeth
11. Dental implants
12. Bone transplants

SILHOUETTE

13. Thigh lift surgery
14. Tummy tuck + waistline
15. Tummy tuck + thigh lift surgery
16. Tummy tuck (abdominoplasty procedure)

SEINS

17. Breast reduction
18. Breast augmentation
19. Breast ptosis

ALOPECIA

20. Hair implants

If you have chosen a breast augmentation surgery, please state your present bra size and the size you wish to obtain:

My present bra size:

The size I wish to obtain:

Medical and surgical history

- Do you suffer from allergies? Yes No
 - If yes, to which type(s) of medication are you allergic?

- Do you suffer from heart problems? Yes No
 - If yes, which:
 - Please describe the treatment you follow now, if any:

.....



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- Do you suffer from diabetes? Yes No
 - If yes, do you follow any prescriptions right now? Yes No
 - Please describe your treatment:
.....
.....
 - Last blood sugar level:
.....
.....

- Are you being treated for any particular ailment?
 - If yes, please specify:
.....

- Do you take any other kind of medication? *Please specify all types of current medication (aspirins, contraceptive pills...)*
 - Treatment # 1 :
 - Treatment # 2 :
 - Treatment # 3 :

- Have you ever had aesthetic surgery before? Yes No
 - If yes, please specify the type of surgery:
 - In which year?

- Have you ever had any other type of surgery before (other than aesthetic surgery) ? Yes No
 - If yes, please specify the type of surgery:
 - In which year?

Your stay

PLEASE VERIFY THAT YOUR PASSPORT IS VALID

- When would you like to have your treatment(s) / surgery (-ries) performed?
 - In this period (first priority):
 - Or in this period (second priority):
 - Or in this period (third priority):

- Would you like us to organize your hotel accommodation in combination with the treatment? Yes No

- In which hotel would you like to stay? _____

- Would you like to undertake any particular activities during your stay (treatments, excursions,...)

Please make sure to attach photos (front and profile) of the area concerned. We will not be able to respond to your demand and send you a personalized offer including the advice of our surgeons, unless we have received photos of the area concerned.