CONSULTATION FORM – **BREAST ENHANCEMENT**

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| Date: | Click or tap to enter a date. |

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| First and last name:  | Click or tap here to enter text. |
| Gender: | Choose an item. | Age: | Click or tap here to enter text. |
| Height: | Click or tap here to enter text. | Weight: | Click or tap here to enter text. |
| Occupation: | Click or tap here to enter text. | Marital Status:  | Choose an item. |
| Address: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |
| E-mail: | Click or tap here to enter text. |

Please take two photos of your breasts, one from the front and the other from the profile and submit it along with the form. (Like the sample photos):

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| How did you hear about us? Google, Instagram, Facebook, Twitter, friends, other? |
| Click or tap here to enter text. |
| Please provide your transaction details (date of deposit, name, surname and your PayPal e-mail address):  |
| Click or tap here to enter text. |
| What is your breast size (The band size and the bust size)? |  |
| ☞ The bust size is the loose circumference measured around the chest over the fullest part of the breasts while standing straight with arms to the side and wearing a properly fitted bra.☞ The band or frame size is the firm circumference, fitted not tightly, measured directly underneath the breasts. |
| The bust size: Click or tap here to enter text.The band size: Click or tap here to enter text. |
| What is your purpose for treatment? |
| [ ]  A: To increase my breast size[ ]  B: To make my breasts firmer[ ]  C: Both |
| How many sizes do you want to increase your breasts? Please write your ideal breast size. |
| Click or tap here to enter text. |
| Have you been pregnant before? |
| Click or tap here to enter text. |
| Did you breastfeed before? |
| Click or tap here to enter text. |
| Are you suffering from breast diseases? If so, please explain. |
| Click or tap here to enter text. |
| Have you ever performed breast augmentation, implants, or other breast surgeries? |
| Click or tap here to enter text. |
| Do you have ovarian cysts? |
| Click or tap here to enter text. |
| Do you smoke? If so, on average, how many cigarettes per day? |
| Click or tap here to enter text. |
| Do you drink alcohol? If so, how much? |
| Click or tap here to enter text. |
| Do you use drugs? What kind, and how often? |
| Click or tap here to enter text. |
| Do you have any medication or food allergies? |
| Click or tap here to enter text. |
| Do you exercise? What kind of exercise and how many hours per week? |
| Click or tap here to enter text. |
| How many hours do you sleep at night? Do you have problems such as insomnia or excessive sleepiness? Please explain. |
| Click or tap here to enter text. |

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| If you have any disease, please fully explain. |
| Click or tap here to enter text. |
| Please write a complete history of your parents’ illnesses such as cancer, diabetes, hypertension, kidney problems, etc. |
| Click or tap here to enter text. |
| Please list all medications or natural supplements you are currently taking, and for what conditions? |
| Click or tap here to enter text. |
| How many caffeinated beverages do you consume per day? |
| Click or tap here to enter text. |

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| At the end, if you have any additional explanation about your physical condition, please write. |
| Click or tap here to enter text. |

Name and Signature:

Click or tap here to enter text.

Please draw your signature here

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1. The applicant is responsible for the accuracy of the information in the form. The applicant must complete the treatment form accurately and keep the physician fully informed of his or her condition, illnesses and medications.
2. I allow the use of my photos on Dr. Nasirzadeh's website and social networks.
3. I have read the FAQ page thoroughly, and I am fully aware of the treatment process and the chance of getting a result.