Patient Demographics

- **Full Name:** _____
- **Date of Birth:** (DD/MM/YYYY) **//**_____
- **Age:** _____ years
- **Gender Identity:** _____
- **Contact Number:** _____
- **Email Address:** _____
- **Marital Status:** _____
- **Occupation:** _____
- **Emergency Contact Name:** _____
- **Emergency Contact Relationship:** _____
- **Emergency Contact Number:** _____

II. Medical History

- **Primary Care Physician:** _____
- **Last Physical Exam Date:** _____
- **Known Allergies (Medications, Latex, etc.):** _____

- **Current Medications (Prescription, OTC, Supplements, Herbal):**

- **Past Medical History (Please check all that apply and provide details):**
    - [ ] High Blood Pressure
    - [ ] Diabetes
    - [ ] Heart Disease
    - [ ] Lung Disease (Asthma, COPD)
    - [ ] Kidney Disease
    - [ ] Liver Disease
    - [ ] Bleeding Disorders / Easy Bruising

- [ ] Blood Clots (DVT/PE)
- [ ] Autoimmune Disease (e.g., Lupus, Rheumatoid Arthritis)
- [ ] Thyroid Disorder
- [ ] Depression/Anxiety
- [ ] Eating Disorder
- [ ] Body Dysmorphic Disorder (BDD)
- [ ] Other significant medical conditions: _____

- **Past Surgical History (Please list all previous surgeries and dates):**

- **Social History:**
  - **Smoking/Nicotine Use (Cigarettes, Vaping, etc.):** [ ] Yes [ ] No
    - If Yes, frequency/duration: _____
    - Are you willing to quit before surgery? [ ] Yes [ ] No
  - **Alcohol Consumption:** [ ] Yes [ ] No
    - If Yes, frequency/amount: _____
  - **Recreational Drug Use:** [ ] Yes [ ] No
    - If Yes, type/frequency: _____

III. Gynecological & Obstetrical History

- **Age at First Period (Menarche):** _____
- **Menstrual Cycle:** [ ] Regular [ ] Irregular [ ] Post-Menopausal
- **Number of Pregnancies:** _____
- **Number of Vaginal Deliveries:** _____
- **Number of C-sections:** _____
- **History of Vaginal Infections (Yeast, Bacterial Vaginosis):** [ ] Yes [ ] No
  - If Yes, frequency: _____

- **History of STIs:** [ ] Yes [ ] No
    - If Yes, please specify: _____
- **Last Pap Smear Date & Result:** _____

IV. Concerns & Goals for Consultation

- **What are your primary concerns regarding your labia majora/genital area?** (Please be specific.)
    - [ ] Size (Too large)
    - [ ] Appearance (Shape, Symmetry)
    - [ ] Sagging/Laxity
    - [ ] Loss of Volume/Deflated appearance
    - [ ] Discomfort with clothing (e.g., tight pants, swimwear)
    - [ ] Discomfort during exercise (e.g., cycling, running)
    - [ ] Discomfort during sexual activity
    - [ ] Hygiene concerns
    - [ ] Self-consciousness/Impact on body image
    - [ ] Other: _____
- **How long have you had these concerns?** _____
- **What are your specific goals for this procedure? What outcome are you hoping for?**

- **Have you previously consulted other surgeons or sought treatment for these concerns?** [ ] Yes [ ] No
    - If Yes, please describe: _____
- **How did you hear about our clinic/Dr. [Surgeon's Name]?** _____

V. Psychological & Lifestyle Questions

- **How do you feel about your overall body image?** _____
- **Have these concerns about your labia majora significantly impacted your daily life, relationships, or self-esteem?** [ ] Yes [ ] No
    - If Yes, please explain: _____

- **Do you have realistic expectations about the surgical outcome?** [ ] Yes [ ] No
- **Are you experiencing any significant stress or major life events currently?** [ ] Yes [ ] No
    - If Yes, please describe: _____
- **Are you currently taking any psychiatric medications or undergoing therapy?** [ ] Yes [ ] No
    - If Yes, please specify: _____

VI. Consent for Consultation

- I understand that this form collects sensitive medical information necessary for my consultation.
- I certify that the information provided in this form is true and accurate to the best of my knowledge.
- I understand that this consultation will involve a physical examination, discussion of my concerns, and potential treatment options.

Patient Signature: _____ Date: _____