



Aesthetic Plastic Surgery Center
Dermatology and Laser Center

Medical Inquiry Form

Thank you for giving PAI (Preecha Aesthetic Institute) the opportunity to provide you with Aesthetic Plastic surgery options available through our institute. With our doctors, we have to make sure your client will receive the best results.

We have put together a medical form designed to look out for potential problems that would put you at any type of risk during your medical journey.

Please note, that at some point, your surgeons abroad may require you're X-rays: MRI's and other medical documents. Please email them to us at Consult@pai.co.th or mail them to our operations department at:

Attn: Peera Tiewtranon
PAI (Preecha Aesthetic Institute)
898/1 Sukumvit Soi 55
Wattana, North Klong toei
Bangkok, Thailand 10110

Contact Information			
Last Name		First Name	
E-mail Address		Phone #	
Address		Address #2	
City		State	
Zip/Postal Code		Country	

Emergency Contact Information			
Last Name		First Name	
E-mail Address		Phone #	
Address		Address #2	
City		State	
Zip/Postal Code		Country	

Requested Procedure

(Please provide us with as much detail as possible).

Please tell us which procedure you are interested in receiving:

Why are you interested in receiving the above procedure?

(Please be as honest as possible when responding to the above question - it is important that the doctor truly understands the purpose).

General Information/Statistics			
Gender			
Height			
Weight			
Date of Birth			

Medical Conditions					
Are you/have you ever had:					
Aids or HIV positive	Yes	No	Anemia	Yes	No
Arthritis	Yes	No	Asthma	Yes	No
Back Problems	Yes	No	Blood Clots	Yes	No
Blood Disorders	Yes	No	Bleeding Problems	Yes	No
Breathing Problems	Yes	No	Cancer	Yes	No
Chest Pains	Yes	No	Colitis	Yes	No
Depression	Yes	No	Diabetes	Yes	No
Ear Problems	Yes	No	Eye Problems	Yes	No
Epilepsy	Yes	No	Heart Problems	Yes	No
Heart Murmur	Yes	No	Hepatitis	Yes	No
High Blood Pressure	Yes	No	Irregular Heartbeat	Yes	No
Stroke	Yes	No	Any psychiatric conditions	Yes	No
Migraine Headaches	Yes	No	Seizures	Yes	No

Nose/Throat Problems	Yes _____ No _____		
Pneumonia	Yes _____ No _____		
Rheumatic Fever	Yes _____ No _____		
Shortness of Breath	Yes _____ No _____		
Stomach Problems	Yes _____ No _____		
Thyroid Problems	Yes _____ No _____		
Transfusion	Yes _____ No _____		

For Women Only

Do you take birth control pills or any hormone replacement medication or patches?	Yes _____ No _____
Are you pregnant?	Yes _____ No _____
(Pregnant women must take a pregnancy test before departure as most pregnancies can disrupt surgery)	

Medical History	
In the past 18 months, have you been hospitalized, had surgery or received medical treatment, pregnancy delivery, or ambulatory surgery?	Yes _____ No _____
What was your date of surgery?	
What was your reason for surgery?	
Which procedure did you have?	
What was your date of surgery?	
What was your net weight change since surgery?	
Do you have difficulty with healing or scarring?	Yes _____ No _____
Have you had cosmetic surgery in the past?	Yes _____ No _____
If yes, please explain how your experience was:	
Please list any other past surgeries:	

Medication	
Kindly list all the medication you take, along with the dosage:	
Are you allergic to any medication?	Yes _____ No _____
If yes, please explain which medication(s) along with the reaction(s)	
Have you had problems with anesthesia?	Yes _____ No _____
Are you allergic to any type of food or latex?	Yes _____ No _____
Do you take any vitamins or herbal supplements?	Yes _____ No _____
If yes, please explain which ones:	
Do you smoke?	Yes _____ No _____
If yes, how much do you smoke? Per day, per week, per month?	
Do you drink alcohol?	Yes _____ No _____
If yes, how much? Per day, per week, per month?	

