MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female Male

Family Doctor: _____ Phone: _____

Which body area/areas or condition would you like treated?

Please answer all of the following questions:	**Yes**	**No**

1. Do you have **ANY** current or chronic medical illnesses?

   Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.

   Please List:

2. Do you have **ANY** current or chronic skin conditions?

   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

   Please List:

3. Are you currently under a doctor's care? If so, for what reason?

   _____

4. Do you take/use ANY medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis?

   Please List:

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?

   Please List: _____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?
7. Do you have ANY allergies to medications, foods, latex or other substances?

   Please List: _____

8. **(For women)** are you or could you be pregnant?
9. **(For women)** are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?
10. Do you have a history of herpes I or II in the area to be treated?
11. Do you have a history of keloid scarring or hypertrophic scar formation?

Please answer all of the following questions: **Yes** **No**

12. Do you have a history of light induced seizures?
13. Do you have any open sores or lesions?
14. Do you have any history of radiation therapy in the area to be treated?
15. In the last six (6) months, have you used any of the following:
    anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications?

    Please List product name and date last used:

16. In the last three (3) months, have you used any of the following products:
    glycolic acid or otheralphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments?

    Please List product name and date last used:

17. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates:

    _____

18. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®?
    If yes, please list locations on or in the body and dates:

    _____

19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?
20. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?
21. Have you ever had a problem when having your blood drawn?
22. Do you think that you sweat more than normal or are an excessive sweater?
23. Do you have a history of fainting or passing out?
24. Do you consider yourself to have an anxious or nervous personality?
25. Have you been diagnosed with an anxiety disorder?
26. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4 weeks?

SculpSure Office Policy

- A $600 Deposit is Required to schedule a SculpSure Series. The Balance is Due in Full at 1st Treatment.
- An Additional 5% Discount is offered to Cash Payors.
- 48 Hour Notice of Cancellation is Required to Avoid $200 Fee.

Signature: _____ Date: _____