PLEASE CIRCLE ALL PROCEDURES / TOPICS THAT YOU MAY BE INTERESTED IN RECEIVING INFO ABOUT:

SKIN TIGHTENING	SculpSure BODY CONTOURING
ROSACEA	TempSure ENVI BODY
ACNE	TempSure ENVI FACE
ACNE SCARS	SilkPeel Demalinfusion
BROKEN CAPILLARIES	COLLAGEN P.I.N / MICRONEEDLING
DRY SKIN	PicoSure FACIAL LASER
OILY SKIN	PicoSure TATTOO REMOVAL
SURGICAL SCARS	ICON 1540 FRACTIONAL LASER
LIVER SPOTS / AGE SPOTS	IPL/PHOTOFACIAL
CELLULITE	VECTUS HAIR REMOVAL
HAIR REMOVAL	INJECTABLES
SUN DAMAGE	SKINCARE PRODUCTS
BODY FAT	NECK / UNDER CHIN CONTOURING
ROUGH TEXTURE	HYPERPIGMENTATION
FINE LINES / WRINKLES	

MEDICAL HISTORY
PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

1) Do you have **ANY** current or chronic medical illnesses?
Please disclose any history of heat urticarial, 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 Below:

_____

2) Do you have **ANY** current or chronic skin conditions?
Also disclose any history of vitiligo, eczema, melisma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other condition or illness.

Please List Below:

_____

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

Please List Below:

_____

4) Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? Please indicate if you take/use **ANY** systemic/oral steroids (e.g., prednisone, dexamethasone)?

Please List Below:

_____

5) Do you have a Daily & Nightly Skin Care Regimen?

Please List Daily Skin Care Regimen:

_____

Please List Nightly Skin Care Regimen:

_____

MEDICAL HISTORY CONTINUED
PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

6) Do you have **ANY** allergies to medications, foods, latex, or other substances?

Please List Below:

_____

7) (For Women) are you or could you be pregnant? **CIRCLE: YES OR NO**

8) (For Women) are menstrual periods irregular, or have you ever been diagnosed with Polycystic Ovarian Disorder or a menstrual dysfunction? **CIRCLE: YES OR NO**

9) Do you have a history or herpes 1 or 2 in the area to be treated? **CIRCLE: YES OR NO**

10) Do you have a history of keloid scarring or hypertrophic scar formation? **CIRCLE: YES OR NO**

11) Do you have a history of light induced seizures? **CIRCLE: YES OR NO**

12) Do you have any open sores or lesions? **CIRCLE: YES OR NO**

13) Do you have any history of radiation therapy in the area to be treated?
CIRCLE: YES OR NO

14) 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 Below:

_____

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

Please List Below:

_____

16) Do you use Makeup? **Please List What Kinds (ex: foundation, eyeliner, eye shadow):**

_____

MEDICAL HISTORY CONTINUED
PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

17) In the last three (3) months, have you used any of the following products: Glycolic acid, other alpha hydroxyl, or beta hydroxyl acid products? Any exfoliating or resurfacing products or treatments?

Please list product name and date last used:

_____

18) Do you have or have you ever had any permanent make-up, tattoos, implants, or dermal fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.?

Please list locations on or in the body & dates:

_____

19) Do you have or have you ever had any Botulinums, such as Botox®, or Dysport®?

Please list locations on or in the body & dates:

_____

20) Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?
CIRCLE: YES OR NO

21) Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?
CIRCLE: YES OR NO

22) Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? **CIRCLE: YES OR NO**

Signature: _____ Date: _____