MEDICAL HISTORY FORM

Last Name: ______________________ First Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Date of Birth: ______________________ Sex: Female ❒ Male ❒

Telephone: Home: ______________________ Work: ______________________

Cell: ______________________

Family Doctor: ______________________ Phone: ______________________

Pharmacy: ______________________ Phone: ______________________

Emergency Contact: ______________________ Phone: ______________________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

	YES	NO
1. Do you have **ANY** current or chronic medical illnesses we should know about? Please List: ______________________	❒	❒
2. Are currently under a doctor's care? If so, for what reason?	❒	❒
3. Do you take/use **ANY** medications, herbal or natural supplements or topicals on a regular or daily basis? Please List: ______________________	❒	❒
4. Do you have **ANY** allergies to medications, foods, latex or other substances? Please List: ______________________	❒	❒

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	YES	NO
5. (For women) are you or could you be pregnant?	❒	❒
6. (For women) are menstrual periods regular?	❒	❒
7. Do you have a history of herpes I or II in the area to be treated?	❒	❒
8. Do you have a history of keloid scarring?	❒	❒
9. Have you taken Accutane or anticoagulants in the last 6 months?	❒	❒
10. Do you have any permanent make-up, implants or tattoos? If yes, please list locations. ______________________	❒	❒
11. Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks?	❒	❒
12. Which body area/areas or condition would you like treated?	❒	❒

Signature: ______________________ **Date:** ______________________