



# SculpSure®

## Medical History

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

**Please answer all of the following questions**

1. Do you have **ANY** current or chronic medical illnesses.....  YES  NO

*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? .....  YES  NO

*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?  YES  NO

\_\_\_\_\_

4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? .....  YES  NO

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? .....  YES  NO

Please List: \_\_\_\_\_

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? .....  YES  NO

7. Do you have **ANY** allergies to medications, foods, latex or other substances? .....  YES  NO

Please List: \_\_\_\_\_

**MEDICAL HISTORY, CONTINUED**

- |  | <b>YES</b>                   | <b>NO</b>                   |
|--|------------------------------|-----------------------------|
| 8. Are you or could you be pregnant? .....   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Are menstrual periods regular? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Have you ever been diagnosed with Polycystic Ovarian Disorder? .....   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Do you have a history of herpes I or II in the area to be treated? .....   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Do you have a history of keloid scarring or hypertrophic scar formation? .....   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 13. Do you have a history of light induced seizures? .....   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 14. Do you have any open sores or lesions? .....   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 15. Do you have any history of radiation therapy in the area to be treated? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 16. In the last six (6) months, have you used any of the following: .....<br>anticoagulants or blood-thinning medications; photosensitizing medications;<br>or anti-inflammatory or blood thinning medications?<br>Please List product name and date last used: _____<br>_____     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 17. In the last three (3) months, have you used any of the following products:<br>glycolic acid or other alphahydroxy or betahydroxyacid acid products;<br>exfoliating or resurfacing products or treatments? .....<br>Please List product name and date last used: _____<br>_____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 18. Do you have or have you ever had any permanent make-up, tattoos, implants,<br>or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? .....<br>If yes, please list locations on or in the body and dates: _____<br>_____                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 19. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? .....<br>If yes, please list locations on or in the body and dates: _____<br>_____  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 20. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 21. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 22. Have you ever had a problem when having your blood drawn? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 23. Do you think that you sweat more than normal or are an excessive sweater? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 24. Do you have a history of fainting or passing out? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 25. Do you consider yourself to have an anxious or nervous personality? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 26. Have you been diagnosed with an anxiety disorder? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 27. Have you had any unprotected sun exposure, used tanning creams (including<br>sunless tanning lotions) or tanning beds or lamps in the last 4 weeks? .....  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Signed: \_\_\_\_\_

Date: \_\_\_\_\_