SculpSure® Medical History Consultation Form

Last Name: ______________________________________ First Name: ___________________________

Telephone: Home: _________________ Work: _________________ Cell: _________________________________

Date of Birth: ______________________ Sex: ☐ Female ☐ Male

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

		YES	NO
1.	Do you have **ANY** current or chronic medical illnesses? *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: ____ ____	☐	☐
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 in the treatment area.* 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 non-prescriptions), 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 in the treatment area? 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/nursing?**	☐	☐
9.	(For women) Are menstrual periods irregular?	☐	☐
10.	Have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
11.	Do you have a history of herpes I or II in the area to be treated?	☐	☐

		YES	NO
12.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
13.	Do you have a history of light induced seizures?	☐	☐
14.	**Do you have any open sores or lesions?**	☐	☐
15.	**Do you have a history of hernias in the treatment area? If yes, repaired? ___Yes ___No**	☐	☐
16.	Have you had a previous procedure or surgery in the treatment area that may have resulted in decreased sensation, scar/fibrotic tissue or large scars that may interfere with the treatment?	☐	☐
17.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
18.	Do you have a history of skin photosensitivity disorders?	☐	☐
19.	Do you have a history of neuropathic disorder, impaired skin sensation or Diabetic Neuropathy?	☐	☐
20.	**Have you ever had Parenteral Gold Therapy (gold sodium thiomalate) for arthritis?**	☐	☐
21.	In the last six (6) months, have you used any of the following: Anti-coagulants or blood-thinning medications, photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: ____ ____	☐	☐
22.	In the last three (3) months, have you used any of the following products: Glycolic acid or other alphahydroxy or betahydroxy acid products; exfoliating or resurfacing products or treatments in the treatment area? Please List product name and date last used: ____ ____	☐	☐
23.	Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Juvederm, Restylane®, etc. in the treatment area? If yes, please list locations on or in the body and dates: ______________________________________ ____	☐	☐
24.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
25.	Have you used Tretinoin (like Retin-A®, Renova®) in the treatment area?	☐	☐
26.	Have you ever had a problem when having your blood drawn?	☐	☐
27.	Do you think that you sweat more than normal or are an excessive sweater?	☐	☐
28.	Do you have a history of fainting or passing out?	☐	☐
29.	Do you consider yourself to have an anxious or nervous personality?	☐	☐
30.	Have you been diagnosed with an anxiety disorder?	☐	☐
31.	Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 7 days in the treatment area?	☐	☐

Signature: ____ Date: ________________________

Print Name: ____

Reviewed by: ____ Date:________________________

Physician (if necessary): _________________________________ Date:_________________________