Adieu

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:** ________________