412 Jungermann Road
203
St. Peters, MO. 63376
636-205-4070

MEDICAL HISTORY

Patient Name: _____ DOB: _____

Address: _____
Phone Number: _____ Email: _____

Chief Complaints (What brought you in today?):

_____
_____
_____

Bucket List (what would you like to have done in the future?)

_____
_____
_____

Do you have an allergy to any of the following (check all that apply):

- ☐ Latex
- ☐ Iodine
- ☐ Shellfish
- ☐ Milk
- ☐ Lidocaine
- ☐ Fentanyl
- ☐ Midazolan
- ☐ Augard
- ☐ Propofol
- ☐ Other: _____

Medications (including over the counter vitamins or GNC medications):

_____
_____
_____

Surgeries:

_____
_____
_____

Have you had any filler or Botox treatments in the past? If so, what areas?

_____
_____
_____

Have you had any liposuction treatments in the past? If so, what areas?

_____

Have you had any kind of laser treatments in the past? If so, what type of laser treatment and what areas?

Do you have any artificial knees, hips, or joints? Do you have any implants, pacemakers, ect?

Do you have any tattoos or piercings? If so, are they in the area we are using the laser?

Please note, if you are having anything vaginally done, we will need your most recent OBGYN Pap smear report.