Medical History

Patient Name: ______________________________ DOB: ____________

Address: ____

Phone Number: ____________________ Email: ______________________

Chief Complaints (What brought you in today?):

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

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

- [ ] Latex
- [ ] Iodine
- [ ] Shellfish
- [ ] Milk
- [ ] Lidocaine
- [ ] Fentanyl
- [ ] Midazolam
- [ ] Augard
- [ ] Propofol
- [ ] Other

Patient Signature______________________________Date: ________________

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

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Surgeries:

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

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

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

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

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

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

Please note if you No-Show 5 or more times you will not be allowed to reschedule.

Patient Signature____Date: ______________________