SCULPSURE® MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Telephone: Home: _____ Cell: _____

Date of Birth: _____ Sex: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas 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 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 <u>any</u> 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 <u>any</u> other skin condition.		
Please List: _____		
6. (For women) are you or could you be pregnant?	☐	☐
7. Do you have **ANY** allergies to latex, corn, or gold?	☐	☐
Please List: _____		
8. Have you ever taken oral or injected gold therapy?	☐	☐
9. Do you have a history of herpes I or II in the area to be treated?	☐	☐
10.		
11. Do you have a history of light induced seizures?	☐	☐
12. Do you have any open sores or lesions?	☐	☐
13. Do you have any history of radiation therapy in the area to be treated?	☐	☐
14. In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: _____	☐	☐

15.	Do you have a history of surgery or other treatments, medical or cosmetic, in the area to be treated? If yes, please list: _____	☐	☐
16.	Do you have, or have you ever had a hernia?	☐	☐
17.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
18.	Do you have a history of fainting or passing out?	☐	☐
19.	Have you had any unprotected sun exposure or used tanning beds or lamps in the last week?	☐	☐

By typing your name below, you are consenting this from is factual to the best of your knowledge.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____