Medical History

Name:____

Address:____

Home Phone: ______________ Work: ______________Cell: ______________

Age: _________Referred by_____________________________________

Have you ever had the following?

☐ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi.
☐ Any active infection.
☐ Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
☐ Use of photosensitive medication and/or herbs that may cause sensitivity to 515 - 1200 nm light exposure, such as Isotretinoin, tetracycline, or St. John's Wort.
☐ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications.
☐ Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
☐ History of bleeding coagulopathies, or use of anticoagulants
☐ History of keloid scarring.
☐ Very dry skin.
☐ Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment.
☐ Are you pregnant? ☐Yes ☐ No
☐ What medications are you taking (including aspirin)? ______________________
☐ Daily consumption of alcohol ______________________
☐ Allergies: ______________________
☐ Are you taking any herbal preparations?(St. John's Wort, etc.) ______________________
If yes, list ______________________
☐ Do you wear contact lenses? ☐Yes ☐ No

Skin type (when exposed to the sun <u>without protection</u> for about 1 hour)

☐ always burns, never tans ☐ always burns, sometimes tans
☐ sometimes burns, sometimes tans☐ always tans
☐ Hispanic ☐ Asian ☐ Mediterranean ☐ Middle Eastern ☐ Black

When were you last exposed to the sun (including tanning booth)? ______________________

Do you use chemical sun tanning lotions?____________ Are you planning a holiday in the sun? ____________

Reason for visit (area to be treated) ______________________

Prior treatment (if any) ______________________

Patient History | FemiLift

Renew Aesthetic Clinic

Patient name	D.O.B	Patient Reference ID

(Please answer ALL questions in this section)	Yes	No	*Please give full details, dates, hospitals consulted etc*
Are you pregnant or think you may be pregnant?			
Are you breast feeding?			
When was the date of your last menstrual cycle?			
Date of last pap smear?			
Have you ever had an abnormal pap smear?			

	Yes	No	*If "yes" please give full details, dates, hospitals consulted etc*
Have you recently had any gynecological treatments or surgery?	`		
Do you have implanted mesh or a sling for stress urinary incontinence?			
Are you using aspirin or any blood thinning medication?			
Do you have any general medical history? (eg Epilepsy, Diabetes, Hypertension, Pregnancy)			
Do you have any type of immune deficiency? (eg HIV or Hepatitis)			
Do you have any allergies?			
Do you have any Hormone abnormalities?			
Do you take any prescribed or non prescribed medication or herbal remedies? (eg St Johns wart)			

Patient Signature:	Print Name:	Date:

Practitioner Signature:	Print Name:	Date: