Profound MedSpa
Confidential Patient Medical History

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email: _____

Date of Birth: _____ Sex: Female _____ Male _____

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: _____

   _____

3. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

   _____

4. Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? ☐ ☐

   Please List: _____

   _____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? ☐ ☐

   Please List: _____

6. (For women) are you or could you be pregnant? ☐ ☐

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7.	Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
8.	Do you have **ANY** allergies to medications, foods, latex or other substances?	☐	☐
	Please List: _____		
9.	Have you ever taken oral or injected gold therapy?	☐	☐
10.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
11.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
12.	Do you have a history of light induced seizures?	☐	☐
13.	Do you have any open sores or lesions?	☐	☐
14.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
15.	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: _____		
	_____		
16.	Do you have a history of surgery or other treatments, medical or cosmetic, in the area to be treated?	☐	☐
	If yes, please list_____		
	_____		
17.	Do you have or have you ever had a hernia?	☐	☐
18.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
19.	Do you have a history of fainting or passing out?	☐	☐
20.	Do you consider yourself to have an anxious or nervous personality?	☐	☐
21.	Do you consider yourself claustrophobic or have issues with confinement?	☐	☐
22.	Have you had any unprotected sun exposure or used tanning beds or lamps in the last week?	☐	☐

Signature: _____ Date: _____

Reviewed by:_____ Date:_____