SOUTH COAST FAMILY
MEDICAL CENTER, INC.

SculpSure® Medical History Form

First name: _____ Last name: _____

Date of Birth: _____ Sex: [ ] Female [ ] Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell: _____ Work: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area(s) would you like treated: □ abdomen □ flanks/sides □ inner thighs
□ outer thighs □ underarms □ back/bra line □ upper back armpits □ Other: _____

Please answer all of the following questions

	Yes	No
1. Do you have ANY current or chronic medical illnesses? Please 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 any 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 disease affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin conditions. Please list: _____ _____	□	□
3. Are you currently under a doctor's care? If so, for what reason(s)? _____	□	□
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?	□	□

	YES	NO
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 type 1 or type 2 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 (i.e. Doxycycline), or anti-inflammatory medications?	☐	☐
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. 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. Do you consider yourself to have an anxious or nervous personality?	☐	☐
20. Do you consider yourself claustrophobic or have issues with confinement?	☐	☐
21. Have you had any unprotected sun exposure or used tanning beds or lamps in the last week?	☐	☐
22. Do you have any history of radiation therapy in the area to be treated?	☐	☐

Signature: _____ Date: _____

Reviewed by: _____ Date: _____
Printed name

_____
Signature