Name: _____ Date of Birth: ___ / ___ / _____

Previous Laser Treatments [ ] Yes [ ] No Date Last Treated _____ Area _____

VERJU LASER MEDICAL QUESTIONNAIRE

Current Medical Problems:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Past Medical / Surgical History:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Medications:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Supplements/Vitamins/Herbs/Homeopathic remedies:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergy to Medications: (Encircle) YES NO

If Yes, what? _____

_____

Are you currently pregnant? [ ] Yes [ ] No [ ] Not Sure

Do you have any of the following?

Active Infection/s	[ ] Yes	[ ] No	Herpes I / II	[ ] Yes	[ ] No
Cancer Treatment	[ ] Yes	[ ] No	HIV / AIDS	[ ] Yes	[ ] No
Coagulation Problem	[ ] Yes	[ ] No	Keloids	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No	Open wound on site	[ ] Yes	[ ] No
Heart Condition	[ ] Yes	[ ] No	Pacemaker	[ ] Yes	[ ] No
Hepatitis (Type___)	[ ] Yes	[ ] No	Photosensitizing med	[ ] Yes	[ ] No

By signing below, I certify that the above information that I have provided is true.

Patient Name: _____

Patient Signature: _____ Date Signed: _____