MEDICAL & PERSONAL HISTORY

Dr. Marco Lopez Dr. Roberta Krueger

Name: _____Age:_____ **Date:** _____

Birth Date (mm/dd/yyyy)**: _____/_____/_____ How did hear about us? _____**

Address:_____Apt#_____City: _____St:___ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Occupation:_____**E-mail Address:** _____

Emergency Contact: _____ **Phone:** _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	**Dose (e.g., mg/pill)**	**Reasons For Each**

Allergies or reactions to medications, creams and/or foods:

Allergic to:_____Type of Reaction:_____
Allergic to:_____Type of Reaction:_____
Allergic to:_____Type of Reaction:_____

PERSONAL MEDICAL HISTORY: Please indicate whether you currently have or have had any of the following medical conditions (with dates).

- ☐ Acne
- ☐ Auto-Immune Disease
- ☐ Cardiac Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy/Seizure Disorders
- ☐ Recent Fever/Cold/Flu
- ☐ Gastrointestinal
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Kidney Disorders
- ☐ Liver Disorders
- ☐ Lymphatic Disorders
- ☐ Lipomas (Fatty Tumors)
- ☐ Neurological
- ☐ Organ Transplant
- ☐ Psychiatric
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

1. Do you have any metal implants? (including Mouth/ Jaw area) **YES / NO**

If yes, please explain where: _____

2. Do you have any electrical support systems in your body (i.e. pacemakers, automatic defibrillator, cardioverter)? **YES / NO**
3. Do you have any other type of implantable devices? **YES / NO**
4. Are you currently pregnant or trying to get pregnant? **YES/ NO**
5. Are you Breastfeeding? **YES/ NO**

The treatments, products and prescriptions used at Sculpt Away are contraindicated during pregnancy and when breastfeeding.

6. Are you currently on method of birth control? **Yes / No** **Type Used:**_____
7. Are you post menopausal? **YES/ NO**
8. Have you had a Hysterectomy? **YES/ NO**

A Negative Pregnancy test will be required prior to treatments, products and prescriptions at Sculpt Away if you are NOT USING A BIRTH CONTROL METHOD, HAVE NOT HAD A HYSTERECTOMY OR ARE NOT POST MENOPAUSAL.

The Fee for the Pregnancy Test is $10.

COSMETIC HISTORY & SKIN ASSESSMENT

Ethnicity: □ Caucasian □ Hispanic □ African American □ Asian □ Indian □ Native American □ Other:_____

1. Have you had any complications as a result of any cosmetic procedure(s): **YES / NO**

   If yes, please explain: _____
2. Have you recently had any Botox or soft tissue fillers (i.e. Restylane, Juvederm) **YES / NO**
3. Have you ever used Accutane, Retin A, Renova, Differin, Tretinoin Hydroquinone, Tazorac or any other prescription skin products? **Yes / No**

Is there any other information that you feel my be related to or is pertinent to your treatment? If so, please explain._____

_____

Patient Signature: _____ **Date:** _____