Quanta Shape Medical History Form

Name:_____ **Date of Birth**_____
Adress_____
_____
City_____**State**_____**Zip Code**_____
Best Phone Number_____
Restrictions on contacting you? No ☐ Yes ☐ If yes please specify_____
Email_____
Relevant Medical History:

1. Are you allergic to any medications, latex, foods or other substances? ☐ YES* ☐ NO *If YES Please list:_____
   _____
2. Are you currently taking prescription, herbal, or over the counter medication? ☐ YES* ☐ NO *If YES Please explain:_____
   _____
3. List all past and current medical conditions._____
   _____
   _____
4. Have you had any surgeries? ☐ YES* ☐ NO *If YES Please list:_____
   _____
   _____
5. Do you have any metal in your body? ☐ YES* ☐ NO *If YES Please list and explain:
   _____
   _____
6. Are you currently pregnant or nursing? ☐ YES* ☐ NO
7. If you are a woman of childbearing potential are you using birth control? ☐ YES* ☐ NO* *Please explain:
   _____
   _____

8. Do you have a history of any skin disease or sensitivity? *If YES Please explain:_____

_____

9. Do you know your Skin Type? Fitz. Skin Type: I II III IV V VI

10. What is your daily intake of water (cups)? ☐ 0-2 ☐ 2-4 ☐4-6 ☐ 6-8 ☐ more

11. Do you engage in any light physical activity such as walking? Check which best applies:

☐ Never ☐ Rarely ☐ Sometimes ☐ Always

12. Do any of the discussed contraindications apply to you? ☐ YES* ☐ NO *If YES Please explain:_____

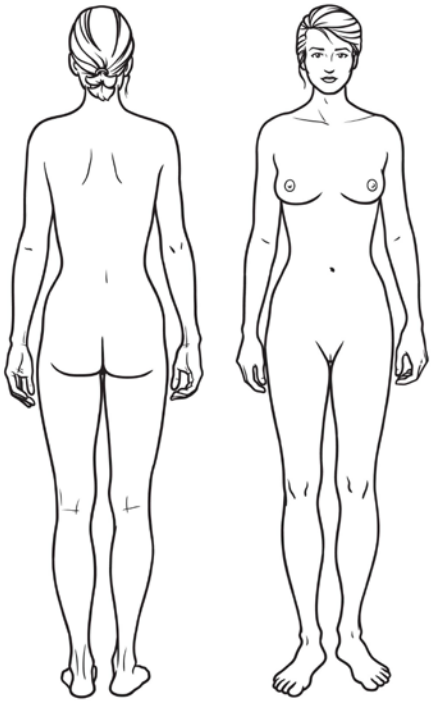
_____

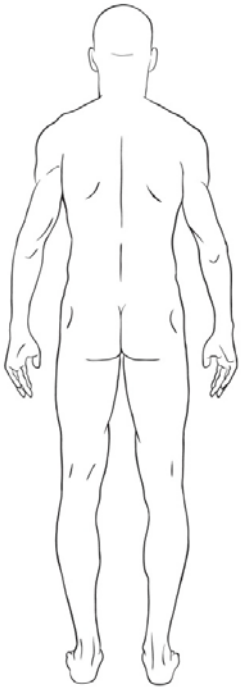
History:	**Yes**	**No**	**N/A**	**Date**
Recent Sun Exposure	X	X	X	_____
Previous Laser Treatments	X	X	X	_____
Hair Removal---				
Waxing, Plucking, Electrolysis	X	X	X	_____
Accutane, last 6 months	X	X	X	_____
Gold Therapy	X	X	X	_____
Coagulopathies	X	X	X	_____
Herpes/Cold Sores	X	X	X	_____
Vitiligo	X	X	X	_____
History Melanoma	X	X	X	_____
Keloids/Hypertrophic Scarring	X	X	X	_____
Tattoos/Permanent Make-up	X	X	X	_____
Fillers, Botox etc.	X	X	X	_____
Pacemaker/Defibrillator	X	X	X	_____
Implants/Surgeries in treatment area	X	X	X	_____
Decreased sensation/Numbness in treatment area	X	X	X	_____

13. Which area(s) are you interested in receiving Quanta Shape treatments? Please list and mark the areas on the diagram.

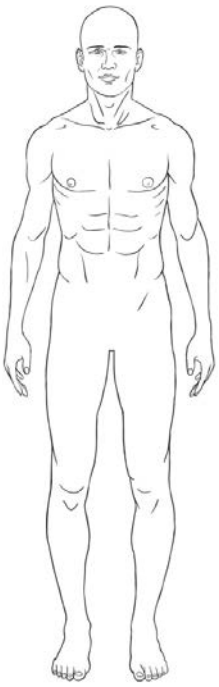
Mark area(s) on diagram:

☐ N/A





☐ N/A



Patient signature below indicates that the above information is accurate and current.

Patient signature:_____

Date:_____

Clinician signature:_____

Date:_____