NEW PATIENT INFORMATION/MEDICAL QUESTIONNAIRE

Today's Date ____/____/____

Last Name _____ First _____ MI _____

Address _____ City: _____ Zip Code_____

Phone : _____ E-mail Address: _____

Occupation _____

Approximate Weight: _____ Height: _____ Date of Birth ____/____/____

Goal or Reason for Visit:

- ☐ ThermiTight
- ☐ J-Plasma Skin Resurfacing
- ☐ Vaginal rejuvenation Thermiva
- ☐ Medical Supervised Diet
- ☐ Thermage / Ultherapy
- ☐ Kybella (Double chin)
- ☐ miraDry – underarm sweat
- ☐ Fraxel & Fractional CO2
- ☐ Botox / Dysport / Xeomin
- ☐ Restylane / Juvederm
- ☐ Radiesse / Voluma
- ☐ J-Plasma Body Contouring
- ☐ Laser Liposuction
- ☐ CoolSculpting
- ☐ Laser Hair Removal
- ☐ Microneedling +/- PRP
- ☐ IPL - Photofacial
- ☐ Microdermabrasion
- ☐ Chemical Peel
- ☐ Laser Tattoo Removal
- ☐ Silhouette Instalift

Please list the prescriptions you are currently taking (including vitamins, herbal, OTC motrin, advil, aleve) : _____

Drug Allergies (Including topical lidocaine): _____

Have you ever had a cold sore on your lip?	No	Yes	Last time: ____
Are you pregnant or breastfeeding?	No	Yes	
Have you used or are you currently using Retin-A or Renova?	No	Yes	Last time: ____
Have you used or are you currently using Accutane?	No	Yes	Last time: ____
Do you smoke?	No	Yes	Quantity: ____
Do you have urine leakage or vaginal dryness?	No	Yes	

If so, ask us how ThermiVA can help?

Please list previous surgeries: _____

PAST MEDICAL HISTORY: Check conditions that doctors have followed you for in the past

- ☐ Diabetes / High Sugar
- ☐ High Blood Pressure
- ☐ Thyroid Problems
- ☐ Kidney / Liver Disease
- ☐ Cardiac Disease or Stroke
- ☐ Seizures / Epilepsy
- ☐ Stomach / Intestinal Problems
- ☐ History of blood clots
- ☐ Urine / Bladder leakage
- ☐ Bleeding disorders / Low platelets
- ☐ Asthma / Lung Problems
- ☐ Hernia (abdominal/umbilical)
- ☐ Cancer
- ☐ HIV
- ☐ Hepatitis B or C

☐ Any Psychiatric or emotional Illness (anxiety/depression/PTSD) **including Body Dysmorphic Syndrome** (please elaborate) _____

I have been given the opportunity to review the HIPAA notice either online or in-office.
Signature: _____