ECLIPTIC MEDI-SPA

PLASMALIFT

Medical History

SURNAME:_____FIRST NAME: _____ EMAIL:_____

D.O.B.: _____ PHONE: _____

MAILING ADDRESS:_____

DOCTORS NAME AND NUMBER: _____

HOW WERE YOU REFERRED TO OUR FACILITY: _____

ALLERGIES TO ANY MEDICATIONS OR FOODS: _____

CURRENT MEDICATIONS: _____

PREVIOUS SURGERIES: _____

HAVE YOU USED OR HAVE YOU HAD ANY OF THE FOLLOWING: (please check)

Accutane ____
Retin-A-Burns ____
Dye Laser ____
Chemical Peel ____
Grafts ____
Glycolic Acid ____
Laser Resurfacing ____
Sunburn ____
Photo-derm ____
Intense Light ____

IF YOU CHECKED ANY, WHEN AND WHICH AREA: _____

DO YOU HAVE ANY OF THE FOLLOWING: (please check)

In Menopause ____
Post Menopause ____
Regular Periods ____
Hormone Imbalance ____
Pregnant ____
Pregnant ____
Breast Feeding ____
Herpes ____
Hepititis C ____
HIV ____
Aids ____
Cancer _____
Depression ____
Mental Illness ____

MEDICAL HISTORY
DO YOU HAVE ANY OF THE FOLLOWING: (please check)

Cancer ____
High Blood Pressure ____
Heart Conditions ____
Keloid Scars ____
Bleeding Disorder ____
Contact Lenses ____
Hemophilia ____
Dermatitis/Eczema ____
Pacemaker ____
Epilepsy ____
Cold Sores ____
HIV ____
Latex Allergy ____
Hypoglycemia ____

I ACKNOWLEDGE THAT ALL THE ABOVE INFORMATION CONTRIBUTED BY ME IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ **DATE:** _____