CAPITAL MEDICAL GROUP

Family Heart Imaging Occupational Aesthetics ----CAPITAL AESTHETICS

# Personal Profile and Health History for Exilis

Name:_____Home Phone:_____

Address:_____Work Phone:_____

City/State/Zip: _____

Date of Birth: _____Age:_____Gender: M____F_____

Occupation: _____ Email address:_____

How did you hear about us?_____

What cosmetic/aesthetic procedures are you interested in?

_____

_____

Please share any questions, concerns or comments:_____

---

**Females:** Are you pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No
Are you planning pregnancy during the course of your treatment? ❑ Yes ❑ No

Please complete the following items of medical history. Please, always inform us of any change in your medical history and/or medications. Please list **all** medications including prescription and over the counter drugs, vitamins, herbs, supplements.

_____

_____

Are you allergic to any medications? ❑ Yes ❑ No Please list medications and reactions._____

_____

Please mark all items that pertain to you:

- ☐ Bleeding Disorders
- ☐ Burns/Skin Grafts
- ☐ Use of Blood Thinners
- ☐ Kidney or Liver Failure
- ☐ Deep Vein Thrombosis
- ☐ Metal Implants
- ☐ Pacemaker
- ☐ current RTG therapy
- ☐ pronounced Edema/swelling
- ☐ Acute Inflammations in treatment area
- ☐ Mental Disease
- ☐ Sensation Disorders
- ☐ Seizures
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Peripheral arterial circulation failure
- ☐ Tuberculosis
- ☐ Tumor Diseases
- ☐ Cardiovascular diseases
- ☐ Any condition that would make you more sensitive to intense heat:

_____

# Personal Profile and Health History for Exilis

☐ Have you had surgery in the area to be treated? If "Yes", please explain

_____

_____

**If the answer to any of the following questions is yes, please provide details in the space provided.**

Are you currently being treated for any medical conditions? Yes No
Explain:_____

Do you smoke? If so # per day?_____ _____ Yes No

Do you drink alcohol? Amount per day? _____ Yes No

Have you used Accutane in the last 6 months? How recently? _____ Yes No

Do you have any active skin diseases or infection in the area to be treated? Yes No

Do you have any skin allergies? Yes No

Are you allergic to latex, lidocaine, or any lotions? Please circle any that apply Yes No

What products are you currently using on your skin?
Describe:

Do you have any metal or other implants? Where? _____ Yes No

Name of your family doctor: _____ Phone No. _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Signature of Client: _____Date: _____

Signature of Dr./APRN/PA-C_____Date:_____