Health History Form

Patient Name:			DOB:		Email:	
Address:				City:		Zip:
Home Phone:		Work Phone:			Cell Phone:	
Referred by:						

ThermiTight sites: Please circle area you are interested in treating

Neck & Jowels Abdomen Back Arms Knees Thighs Buttocks

Current Medications (Include all vitamins, supplements, calcium and dosages) Please circle all that apply & any additional medications

Medications:		
Fish Oil	*Yes*	*No*
Herbs	Yes	No
Vitamin E	Yes	No
Aspirin	Yes	No
Advil, Aleve, Motrin	Yes	No
Coumadin/Heparin	Yes	No

List All Medication Allergies: Please circle all that apply & list any additional allergies

Allergies:		
Novocaine	Yes	No
Betadine/Iodine	Yes	No

Surgical History: Please circle all that apply & list any additional surgeries

Surgeries:		
Facial Surgery or Biopsies:		
Face Lift	Yes	No
Botox	Yes	No
Dermal Fillers	Yes	No

Past Medical History: Please circle all that apply & list any additional medical history

Medical History:		
Hypertension	Yes	No
Bleeding Disorder	Yes	No
Diabetes	Yes	No
Skin Cancer	Yes	No

Signature: **Date:**