LATOUR SKIN CARE CENTER
EXILIS TREATMENT

Client/Patient Medical History

Client/Patient _____DOB:___/___/____
Were you referred?____ If so, by whom?_____
Please list any drug, medical or skin allergies you may have:_____
Please list all medications you are currently taking, including prescription, over-the-counters, vitamins, etc.:_____
_____
Have you ever used blood thinning medications?_____ If yes, what medications?_____
Do you have any metal devices implanted in your body?_____ These could include, but are not limited to, pacemakers, defibrillators, cardiac stents, artificial joints, rods, pins, nerve stimulators, metal surgical mesh? If yes, please list here:_____
Are you pregnant or considering pregnancy in the next 2 months (which would be during your treatment)? _____
Are you currently breastfeeding?_____
Do you smoke?_____ If yes, how much?_____
Do you have, or have you ever had, any of these conditions or procedures listed below (please check yes or no):

	YES	NO	
Current active bacterial infection	□	□	
Current active viral infection	□	□	
Facelift or Lifestyle lift	□	□	
Liposuction or other fat removal process	□	□	
Tattoos in treatment area	□	□	
Facial fillers (Restylane, Juvederm, etc.)	□	□	If yes, list filler, date, and location:_____
Sensitive skin	□	□	If yes, how sensitive?_____
Plastic surgery of any kind	□	□	If yes, where on your body and when?_____
Recent deep chemical peel	□	□	
Recent laser resurfacing	□	□	
Accutane in the last 12 months	□	□	
Autoimmune condition such as lupus or scleroderma	□	□	If yes, what is your diagnosis?_____
History of radiation treatment	□	□	If yes, where on your body and when?_____
Kidney or liver problems	□	□	
Current cancer of any type	□	□	
Blood clots	□	□	
Poor healing	□	□	

Please list any other things you feel that we should know about your overall health:_____
_____
What is your daily intake of water (cups)? □0-2 □2-4 □4-6 □6-8 □more
Have you experienced significant weight change in the past 12 months?____ If yes, please explain:_____
_____
Do you engage in any light physical activity, such as walking? □Never □ Rarely □Sometimes □Always

Thank you for completing this questionnaire for us so that we may provide the best possible service with the best results for you!

_____ _____
Client/Patient Signature Date

_____ _____
Aesthetician Signature Date

_____ _____
Physician Signature Date