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Patient Intake Form for Tempsure

Today's Date					
Name				Date of Birth	
Address				Gender	M / F
Cellphone		Email			

	Medical History*	
Pacemaker / Defibrillator	Yes / No	
Metal Implants	Yes / No	If yes, where:
Current or history of skin cancer / other cancer / pre-malignant moles	Yes / No	If yes, where:
Severe concurrent medical conditions (e.g., cardiac disorders)	Yes / No	
Are you on a blood thinner?	Yes / No	
Pregnancy and Nursing	Yes / No	
Impaired Immune System	Yes / No	
Are you on immunosuppressants	Yes / No	
Diseases stimulated by Light (e.g., Lupus, Porphyria, Epilepsy)	Yes / No	
Diseases stimulated by Heat (e.g., Herpes Simplex, Herpes Zoster or Shingles	Yes / No	
Hepatitis B or C	Yes / No	
HIV/ AIDS	Yes / No	
Endocrine Disorders (e.g., DM)	Yes / No	
History of Bleeding Disorders	Yes / No	
Use of medication/herbs inducing photosensitivity such as Accutane, Antibiotics (Cipro, Doxycycline, Levaquin, Tetracycline), Antihistamines (Benadryl, Cetirizine, Claritin, Promethazine), Birth-Control Pills, Estrogen, Diuretics (Furosemide, HCTZ), Estrogen, Glipizide, Glyburide, Celecoxib, Ibuprofen, Naproxen, Psoralens, Statins, Sulfonamides,	Yes / No	
Active Skin Infection (e.g., Eczema, Psoriasis)	Yes / No	
Skin Disorders (e.g., Keloids, Hypertrophic Scars, abnormal wound healing)	Yes / No	
Surgical procedures	Yes / No	If yes, what and how long ago?

Name of Patient:

History of Ventral / Abdominal / Inguinal hernia surgery	Yes / No		If yes, when?
	Yes	No	If Yes, how long ago?
IPL/Lasers/RF			
Ablative Fractional Lasers / RF			
Superficial Bio-Fillers (HA, Sculptra, Artecoll, Radiesse)			
Deep Bio-Fillers			
Superficial Implants (silicone, calcium hydroxyapatite)			
Deep Implants			
Neurotoxins (Botox, Dysport, Xeomine)			
Accutane			
Superficial/Medium Chemical Peeling			
Deep Chemical Peeling Dermabrasion, Non-fractional Laser Resurfacing			
Skin Care Products			
FaceTite			
Air Cooling			
Spray Tan			
List any medications:			
List any allergies:			
Detail any medical condition:			
Other considerations:			

*Note: Failure to disclose full, complete, & truthful medical information to Clinician may result in dissatisfactory results.

Patient Intake Form Agreement

I, (Patient Name) ____, hereby declare that the above information is true and complete. I confirm that I have informed the medical staff regarding any current or past medical condition, disease, and/or medication taken. I am aware that should I develop any untoward side effects or results which are attributable to false or incomplete medical information, I will not hold liable Dr. Eileen C. Comia and the Advance Biomedical Treatment Center medical staff.

____ ____________________

Patient Signature Date Signed

If patient is a minor, parent/guardian must sign below.

____ ____________________

Parent / Guardian Signature Date Signed

PHYSICIAN CONSULT NOTE