Name: _____ Date of Birth: _____

Prior TempSure Therapy ☐ Yes ☐ No Date Last Treated _____ Area_____

TEMPSURE MEDICAL QUESTIONNAIRE

Current Medical Problems:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Past Medical / Surgical History:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Medications:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Supplements/Vitamins/Herbs/Homeopathic remedies:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergy to Medications: ☐ YES ☐ NO

If Yes, what? _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Not Sure

Do you have any of the following?

Active Infection	☐ Yes ☐ No	Blood thinner Use	☐ Yes ☐ No		
Autoimmune Dis.	☐ Yes ☐ No	Herpes Simplex	☐ Yes ☐ No	Pacemakers	☐ Yes ☐ No
Alcohol Intoxication	☐ Yes ☐ No	Use of Pain Killers	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Nerve Insensitivity	☐ Yes ☐ No	Implantable devices	☐ Yes ☐ No	Wound in Area	☐ Yes ☐ No

By signing below, I certify that the above information that I have provided is true.

Patient Signature: _____ Date Signed: _____

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