

Name: _____ Date of Birth: _____

Prior VERJU Therapy ___ Yes ___ No Date Last Treated _____ Area _____

VERJU 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	HIV / AIDS ___ Yes ___ No	Pacemaker ___ Yes ___ No
Cancer Treatment ___ Yes ___ No	Herpes I / II ___ Yes ___ No	Diabetes ___ Yes ___ No
Coagulation Issue ___ Yes ___ No	Keloids ___ Yes ___ No	Open Wound on Site ___ Yes ___ No
Hepatitis (Type ___) ___ Yes ___ No	Photosensitizing med ___ Yes ___ No	

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

Patient Signature: _____ Date Signed: _____