T&T MEDSPA
WELLNESS FOR YOUTHS AND ADULTS

RADIO FREQUENCY MEDICAL HISTORY FORM FOR TEMPSURE

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated? _____

_____

_____

Please answer all of the following questions **YES NO**

1. Do you have **ANY** current or chronic medical illnesses? ☐ ☐

Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.

Please List: _____

_____

2. Do you have **ANY** current or chronic skin conditions? ☐ ☐

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

Please List: _____

_____

3. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

_____

4. Do you take/use **ANY** medications (prescription and nonprescription), aspirin, vitamins, herbal or natural supplements, on a regular or daily basis? o o Please List:

_____

_____

5. Have you ever had Gold Therapy Treatment (chrysotherapy, aurotherapy, Gold sodium thiomalate (GST)? ☐ ☐

6. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List: _____

	YES	NO
7. Do you have **ANY** allergies to medications, foods, latex, gold, or other substances?	☐	☐
Please List: _____		
8. (For women) are you or could you be pregnant?	☐	☐
9. Do you have a history of herpes I or II in the area to be treated?	☐	☐
10. Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
11. Do you have any open sores or lesions?	☐	☐
12. Do you have any history of radiation therapy in the area to be treated?	☐	☐
13. In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: _____ _____	☐	☐
14. In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxy acid products, chemical peels, exfoliating or resurfacing products or treatments?	☐	☐
Please List product name and date last used: _____ _____		
15. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates: _____ _____	☐	☐
16. Do you have or have you ever had any Botulinum, such as Botox® or Dysport®?	☐	☐
If yes, please list locations on or in the body and dates: _____ _____		
17. Have you taken Accutane® (or products containing isotretinoin) in the last 6 - 12 months?	☐	☐
18. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 14 days?	☐	☐
19. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 2 weeks?	☐	☐
20. Do you have a pacemaker, implantable Cardia Defibrillators (ICD) or Cardiac Resynchronization Therapy (CRT) devices?	☐	☐
21. Do you have any metal implants or embedded electronic devices?	☐	☐
22. Do you have nerve insensitivity to heat?	☐	☐
23. Do you have a history of bleeding coagulopathies or are you currently taking antiplatelets, thrombolytics, anti-inflammatories or anticoagulants?	☐	☐

Signature: _____Date: _____

SAMPLE Approved per ER: 2008