MonaLisa Touch

Medical History

Client Name: ______________________________ D.O.B: ______________

Address: ____

City: ________________ State: ____________ Zip Code: ______________

Telephone: Home: ____________ Work: ____________ Cell: ______________

Family Doctor: ______________________________ Phone: ______________

Pharmacy: ______________________________ Phone: ______________

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Emergency Contact: ______________________________ Phone: ______________

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

Have you had a pap smear within the last 3 years?............ ☐ YES ☐ NO
- if yes, what year? ____________

Are you pregnant or within 3 months post-partum? .... ☐ YES ☐ NO

Have you experienced a vaginal or vulvar infection within the last week? .... ☐ YES ☐ NO
(Herpes, Candida, HPV, or STD's)

Do you have a history of herpes? .... ☐ YES ☐ NO
- If yes, was a prescription started 48 hours before this procedure? .... ☐ YES ☐ NO

Do you have vaginal or cervical lesions in the treatment area that have not been evaluated and diagnosed? .... ☐ YES ☐ NO

Do you have a history of radiation to the vaginal or colo-rectal tissue? .... ☐ YES ☐ NO
- If yes, what year? ____________

Do you have a history of reconstructive pelvic surgery with "mesh kit"? .... ☐ YES ☐ NO
- If yes, what year? ____________

Do you have a prolapse beyond the hymen? .... ☐ YES ☐ NO

Do you have a history of impaired wound healing (a wound that doesn't heal correctly)? .... ☐ YES ☐ NO

Do you have a history of keloid formation (a raised formation of scar tissue)? .... ☐ YES ☐ NO

Any known anticoagulation treatment or thromboembolic condition? .... ☐ YES ☐ NO
(Managed blood thinners such as Warfarin or Coumadin, any blood clot disorders)

I certify that the information above is accurate. I understand that withholding of information or giving false information will result in unwanted side effects. I have also been given the opportunity to ask questions and understand the information provided.

Signed: ______________________________ Date: ______________