TAGUCHI WOMEN'S CLINIC

VOTIVA PATIENT INFORMATION

GENERAL INFORMATION

Name:________________________ Date of Birth:__________ Date:__________

Address:____

City, State, Zip code:____________________________________

Home Phone:________________________ Cell Phone:______________

Email:________________________________

Occupation:________________________ Referred by:______________

Emergency Contact:____________ Phone:__________ Relationship:__________

Why do you want FORMA V/MORPHEUS8 Treatment?______________________

SKIN HISTORY

Do you get cold sores or fever blisters? ☐Yes ☐No

Do you form thick or raised scars (keloid)? ☐Yes ☐No

Do you develop hyperpigmentation? ☐Yes ☐No ☐I don't know

When were you last exposed to direct sun or a tanning booth?______________________

Do you use self-tanning products? ☐Yes ☐No

Have you ever had skin acid peels? ☐Yes ☐No Date:__________

Have you ever had Microdermabrasion? ☐Yes ☐No Date:__________

What type of skincare products do you currently use?

____

____

PERSONAL HABITS

Do you smoke? ☐Yes ☐No If yes, how many packs per day______________

Do you consume alcohol? ☐Yes ☐No If yes, how often______________

MEDICAL/SURGICAL HISTORY

Are you currently under the care of a physician? ☐No ☐Yes______________________

Do you have any of the following conditions?

- ☐ Arthritis
- ☐ Any active infection
- ☐ Bleeding disorders
- ☐ Bruising
- ☐ Dark spots from pregnancy
- ☐ Diabetes
- ☐ Cancer
- ☐ Chest Pain
- ☐ Epilepsy or Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes simplex/Cold Sores
- ☐ High blood pressure
- ☐ Hormone imbalance
- ☐ HIV/AIDS
- ☐ Metal Implants
- ☐ Neurologic disorder
- ☐ Pacemaker/Defibrillator/ Loop EKG
- ☐ Sensitive teeth
- ☐ Skin cancer or moles
- ☐ Skin injury
- ☐ Vision deficits
- ☐ Thyroid disease
- ☐ Other:____

Do you have allergies to any of the following:

☐ Topical skin care products ☐ Anesthesia ☐ Latex ☐ Food ☐ Plants

☐ **Medications:** ____

____

MEDICAL/SURGICAL HISTORY CONTINUED

Do you take any of the following:

- ☐ Accutane
- ☐ Antibiotics
- ☐ Blood thinners
- ☐ Anti-Depressants
- ☐ Appetite suppressants
- ☐ Aspirin or ibuprofen
- ☐ Cortisone or steroids
- ☐ Hormone/contraceptives
- ☐ Insulin
- ☐ Sedatives
- ☐ Thyroid medication
- ☐ Other: ______________________________

List any prescribed medications: ______________________________

____

Do you take antibiotics before procedures such as dental? ☐Yes ☐No

Are you taking herbal supplements or vitamins? (Black Cohosh, Gingko, Garlic, Turmeric, St John's Wort, Vitamin E, Fish Oil) ☐Yes ☐No If so, what?______________________________

____

____

List all surgeries:

Date	Procedure	Surgeon

Do you have any issues with bruising or bleeding? ☐Yes ☐No

Have you ever had an issue with your nerves or muscles? (Strokes, Bell's Palsy, nerve injury, etc.)

COSMETIC HISTORY

List all (or last) laser and/or injectables such as Botox, Restylane, Radiesse, collagen, fat or other:

Date	Area	Any adverse reactions

OB HISTORY

Are you pregnant ☐ Yes ☐ No

Times Pregnant: __________ How many delivered__________ How many miscarriages__________

Birth weight of largest baby?____________________ Cesarean Section ☐ Yes ☐ No

GYNECOLOGICAL HISTORY

Last PAP Date:________________ PAP Results: ☐ Normal ☐ Abnormal

If abnormal explain:______________________________

Last menstrual Period Date:________________

History of Sexually Transmitted Infection:______________________________

History of Stress Urinary Incontinence:______________________________

I have answered the questions contained in this questionnaire to the best of my knowledge.

I understand it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are any changes to my health in between treatments.

☐ I do not wish to receive any e-mail communications from Taguchi Women's Clinic regarding services.

Signature:______________________________ Date:________________