

OPUS PLASMA MEDICAL HISTORY FORM

Name: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Age: _____ Referred by: _____

Have you ever had the following?

Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi

Any active infection

Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of recurrent Herpes Simplex, Systemic

Lupus Erythematosus, or Porphyria

Use of photosensitive medication and/or herbs that may cause sensitivity to 515 - 1200 nm light exposure, such as Isotret- inoin, tetracycline, or St. John's Wort

Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications

Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under contro

History of bleeding coagulopathies, or use of anticoagulants

History of keloid scarring

Very dry skin

Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment

Are you pregnant? Yes No

Do you wear contact lenses? Yes No

What medications are you taking (including aspirin)? Please list:

Daily consumption of alcohol: _____

Allergies (Please list):

Are you taking any herbal preparations (ex. St. John'sWort, etc.)? Please list:

Skin type (when exposed to the sun without protection for about 1 hour)

When were you last exposed to the sun (including tanning booth)?

Do you use chemical sun tanning lotions? Are you planning a vacation in the sun?

Reason for visit (area to be treated):

Prior treatment(s) (if any):

Client Signature: _____ Date: _____

Reviewed by: _____ Date: _____