VITALITY HEALTH

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Medical History Form for eDermaStamp Microneedling - Collagen Induction Therapy

Name: _____Phone:_____
Address:_____
(Last) (First)
Height: _____ Weight: _____

Occupation: _____

Please list your main areas of concern that you wish to improve with Micro-needling:

1. _____
2. _____
3. _____

Please list all medication (prescription, over-the-counter) and natural products (vitamins, herbs, oils) you are currently taking, including the dose and reason.

Please list any allergies or sensitivities (food/environmental, medications) you currently have or have had previously.

1. _____
2. _____
3. _____
4. _____

Please list all hospitalizations, surgeries, major injuries AND cosmetic procedures you have experienced or had (including the year, outcome, and any complications).

Please check off any of the following conditions that apply to you.

- ☐ Under 18 years of age
- ☐ Pregnant or nursing
- ☐ Current or history of cancer
- ☐ Current or history of pre-malignant moles or skin cancer
- ☐ Any active condition in the treatment area such as sores, active pustular acne, rosacea, keloid or raised scars, septic conditions, psoriasis, eczema, rash
- ☐ Any active autoimmune conditions
- ☐ Consistent tanning either outside or in tanning bed
- ☐ Damaged skin due to excessive fresh tanning
- ☐ Any active bacterial, viral or fungal infections
- ☐ Vascular disorders such as: uncontrolled diabetes, nervous diseases, cardiac disorders, or cancer
- ☐ Any recent use of products such as Accutane or retin A
- ☐ Taking blood pressure, blood thinning or heart medications
- ☐ Actinic (solar) keratosis - immunosuppression
- ☐ Allergy to coconut
- ☐ Allergy to hyaluronic acid

Lifestyle

Are you currently or have you ever been a smoker? □ Past □ Never □ Currently

If so, how many packs a day? _____

How long have you smoked or when did you quit? _____

How much time do you spend outdoors per week? _____

How often do you exercise? _____

What kind of exercise do you do? _____

Diet

How much water do you drink per day? _____

How many times per week do you eat processed or deli meat? _____

How much caffeinated beverages do you drink per day? _____

How much refined sugar do you eat/drink a week? _____

Do you have any dietary restrictions? □ Yes □ No

If so, please specify (e.g. vegan, religious, allergies) _____

Is there anything you feel is important to note that has not been covered in this questionnaire?

_____

_____

_____

Reminders for 72 hours prior to treatment:

- Do not use any retinols or acids or peels
- Do not take vitamin C, E or omega fatty acids or St. Johns Wort

Reminders for 24 hours post treatment because of sensitivity and/or risk of infection:

- No saunas or hot tubs
- No direct sun or application of sunscreens
- No exercise
- Please only use the topicals provided to you by your practitioner for the first 24 hours

I, the undersigned pledge to inform of all changes in my physical condition.
I confirm that I do not suffer from any of the above described conditions.
I declare that the above information is true and correct.

Patient Name: _____

Patient Signature: _____

Date: _____

Practitioner Name: _____

Practitioner Signature: _____

Thank you for completing this form.

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us.