Skin Care Solutions ***Cool Sculpting Medical History***

Name:_____ Date:_____

Address:_____

Home Phone #:_____ Cell #:_____

E-mail Address:_____

Date of Birth:____/____/____ How did you hear about us?_____

Client History:

Have you had any of the following past or present?

Cold Urticaria, Cryoglobulinemia, or Paroxsymal Cold Hemoglobinuria _____

Hernia in area to be treated _____ Raynaud's Disease _____

Areas of Impaired Peripheral Circulation _____ Impaired Skin Sensation _____

Open or Infected Wounds _____ Extensive Eczema or Dermatitis in treatment area_____

Areas of Recent Bleeding or Hemorrhage _____ If yes, where? _____

Medical Surgery____ Type/Where/When_____

Are you pregnant? _____

Please list any oral/patch, topical or over the counter medications you are currently taking. Please include vitamins and or herbal/dietary supplements:

_____

_____

_____

Please list any **allergies and/or allergic reactions:**

_____

_____

Please inform us of any medical health concerns or conditions:

_____

_____

Signature: _____ Date: _____

Witness: _____ Date: _____