# History Card

***For Lipo-Light and/or Lipo-Light Pro Laser Body Contouring***

Name _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Email Address _____ How Referred _____
Previous Treatments [ ] Yes [ ] No Date Last Treated _____ Area _____

**MEDICAL HISTORY**

Are you under a doctor's care? _____
Recent surgery or injury? _____
Allergies: (ex. Latex, Foods, Medictions, Lidocaine) _____
Present Medications: _____
Present Herbal and Vitamin Supplements: _____
Any history of lymphatic disease? Yes [ ] No [ ]
Check all that apply to you:
[ ] hypo/hyper thyroidism, [ ] kidney disease, [ ] liver disease, [ ] currently pregnant, [ ] currently lactating

**Date of Consult:** _____
Height: _____
Weight: _____
BMI: _____
Positioning of Diode: _____
_____
_____

**Notes:** _____
_____
_____
_____

**Followup Measurement Date:** _____
**Followup Measurement:** _____

**Date of 1st Measurement:** _____
Price Quote 1: _____
Number of Sessions: _____
Payment: _____
# Inches Lost: _____
Notes: _____
_____

**Date of 2nd Measurement:** _____
Price Quote 2: _____
Number of Sessions: _____
Payment: _____
# Inches Lost: _____

**Final Measurement Results:** _____

SCHEDULE DATE AND TIME

| | | | |
|---|---|---|---|
| 1 _____ | 4 _____ | 7 _____ | 10 _____ |
| 2 _____ | 5 _____ | 8 _____ | 11 _____ |
| 3 _____ | 6 _____ | 9 _____ | 12 _____ |

**Have you ever had any of the following? If yes, terminated [t] or continued [c]?**

| | | | |
|---|---|---|---|
| Heart Condition | [ ] Yes [ ] No | Pacemaker | [ ] Yes [ ] No |
| Cancer Treatment | [ ] Yes [ ] No | Hepatitis (Type _____) | [ ] Yes [ ] No |
| Diabetes | [ ] Yes [ ] No | HIV | [ ] Yes [ ] No |
| Coagulation Problem | [ ] Yes [ ] No | Keloids | [ ] Yes [ ] No |
| Herpes I/II | [ ] Yes [ ] No | | |

Patient Name: _____ Technician Name: _____

Patient Signature: : _____ Date: _____