MD BODY & MED SPA

Name:_____Cell:_____

Date of Birth:_____ Emergency Contact: _____Phone:_____

Address: _____City:_____ State: _____Zip: _____

Email: _____ How did you hear about us?_____

Please list current medications and allergies: _____

_____

_____

Medical History: Please circle all that apply.

Yes / No Diabetes- if yes, which type _____
Yes / No Insulin Dependant
Yes / No Active Infection
Yes / No Cardiovascular Disease
Yes / No Congestive heart failure
Yes / No Congestive Obstructive Pulmonary Disease (COPD)
Yes / No Congenital Anomaly- if yes, please describe_____
Yes / No Recent Heart palpitations
Yes / No Recent Chest tightness/left shoulder or arm pain
Yes / No Recent Cardiac Surgery
Yes / No Stomach stapling
Yes / No Gastric Bypass/Lap-band surgery
Yes / No Recent Gastro- Intestinal conditions
Yes / No Recent Diarrhea/Constipation
Yes / No Recent Abdominal pain/bleeding
Yes / No Celiac Disease
Yes / No Irritable Bowel Syndrome
Yes / No Currently Pregnant / Breast feeding
Yes / No Liver Disease
Yes / No Kidney Disease
Yes / No Gall Bladder issues
Yes / No Thyroid issues

Yes / No Cryoglobulinemia or Paroxysmal Cold Hemoglobinuria
Yes / No Known sensitivity to cold such as cold urticaria or Raynaud's disease
Yes / No Impaired peripheral circulation in the area to be treated
Yes / No Neuropathic disorders such as post-herpetic neuralgia or diabetic neuropathy
Yes / No Impaired skin sensation
Yes / No Open or infected wounds
Yes / No Bleeding disorders or concomitant use of blood thinners
Yes / No Recent surgery or scar tissue in the area to be treated
Yes / No A hernia or history of hernia in the area to be treated or adjacent to treatment site
Yes / No Skin conditions such as eczema, dermatitis, or rashes
Yes / No Any active implanted devices such as pacemakers and defibrillator's
Yes / No Cancer
If yes, are you in remition? _____
Yes / No Pregnant or Breastfeeding

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date