

**StarLux™ IPL Medical History Form**

**Which body area (s) or condition would you like to be treated for?**

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**List ANY current or chronic medical illnesses (seizures, lupus, diabetes, polycystic ovarian syndrome etc)?**

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**List all medications, herbal/natural supplements, topical skin care that you take (blood thinners, St. John's Wort, Retin A, Antibiotics, Acne medication, etc)?**

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**List all allergies to medications, foods, latex or other substances:**

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**Are you or could you be pregnant? YES  No**

**Are your menstrual periods regular? YES  No**

**Do you experience herpes I or II/Cold Sores? YES  No**

**Do you form keloid scars? YES  No**

**Have you taken Accutane or blood thinners within the last 6 months? YES  No**

**Do you have permanent make-up, implants or tattoos? Please list locations: YES  No**

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**Have you had any unprotected sun exposure, used tanning creams or tanning beds within the last 4-6 weeks? YES  No**

**Patient Signature: \_\_\_\_\_**

**Date: \_\_\_\_\_**