



INMODE PATIENT INFORMATION FORM

PATIENT NAME: _____ **DATE:** _____

MEDICAL HISTORY

ALLERGIES:
CURRENT MEDICATIONS:
PRIOR SURGICAL PROCEDURES:

Do you have any of the following? Please select YES or NO:	YES	NO
PACEMAKER / DEFIBRILLATOR		
METAL IMPLANTS / SILICONE IMPLANTS/ PIERCINGS/ COCHLEAR IMPLANTS		
If YES, explain and list location(s):		
CURRENT OR HISTORY OF SKIN CANCER/ OTHER CANCER / PRE-MALIGNANT MOLES/SUSPICIOUS LESIONS		
SEVERE CONCURRENT MEDICAL CONDITIONS (E.G., CARDIAC DISORDERS, SENSORY DISTURBANCES, UNCONTROLLED HYPERTENSION, AND LIVER OR KIDNEY DISEASE)		
PREGNANCY AND NURSING		
IMPAIRED IMMUNE SYSTEM (AIDS, HIV, IMMUNOSUPPRESSIVE DISEASES)		
ENDOCRINE DISORDERS (E.G. DIABETES, PCOS, THYROID DYSFUNCTION)		
DISEASES STIMULATED BY LIGHT (E.G. LUPUS, PORPHYRIA, EPILEPSY)		
DISEASES STIMULATED BY HEAT (E.G. HERPES SIMPLEX)		
If YES, prophylactic treatment may be recommended prior		
ACTIVE SKIN CONDITION/ INFECTION (E.G. PSORIASIS, ECZEMA)		
SKIN DISORDERS/CONDITIONS (E.G. KELOIDS, ABNORMAL WOUND HEALING, VITILIGO)		
If YES, explain and list location(s):		
HISTORY OF BLEEDING DISORDERS		
USE OF MEDICATION / HERBS INDUCING PHOTSENSITIVITY		
ISOTRETINOIN USE (ACUTANE), LAST 6 MONTHS		
COSMETIC BOTOX/ NEUROTOXINS, LAST 2 WEEKS		
COSMETIC DERMAL INJECTIONS/FILLERS/FAT GRAFTS, LAST 3 MONTHS		
If YES, explain and list location(s):		
FACIAL LASER RESURFACING / DEEP CHEMICAL PEELING, LAST 3 MONTHS		
NEEDLE EPILATION, WAXING OR TWEEZING, LAST 6 WEEKS		
TATTOO OR PERMANENT MAKEUP ON FACE		
TANNED SKIN (SUN, TANNING BEDS OR TANNING CREAMS), LAST 2 WEEKS		

PATIENT SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE

FITZPATRICK SKIN TYPE	I II III IV V VI
TREATMENT RECOMMENDATION	FORMA-I LUMECCA-I MGE

PHYSICIAN SIGNATURE: _____ **DATE:** _____