Power Rejuvenator Pen (PRPen)

Patient Information & Medical History

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Name of Primary Physician: _____ Phone: _____

Please check if you have or ever had:

□ Diabetes □ Hepatitis □ Herpes □ Heart Problems □ Hypertension □ Vascular Disease

□ Thyroid Disease □ Cancer (specify) _____

Year you were diagnosed with Cancer _____ □ Chemotherapy □ Radiation

□ Bleeding Disorder (specify) _____

□ Autoimmune Disease (specify) _____

□ Immune Compromise (specify) _____

□ Osteoporosis □ Rheumatoid Arthritis □ Osteoarthritis □ Psoriasis or Eczema □ Skin Moles

□ Keloid Scars □ Other Illness (specify) _____

□ Severe Allergic Reaction (specify) _____

□ Allergies to Medications (specify) _____

□ Allergies to Food (specify) _____

List all medications you are currently taking: _____

Are you pregnant or lactating (nursing)? Y/N If yes, you are not a candidate for treatment at this time

Are you trying to get pregnant? Y/N If yes, a pregnancy test is needed before treatment (results) _____

□ Post-Menopausal □ Photosensitivity □ Do you use sunscreen daily? □ Do you take aspirin daily?

□ Do you take anti-inflammatory medications? (Steroids, Naproxen, Hydrocortisone, Ibuprofen)

If so specify _____

When was the last time you took one of these medications? _____

Do you agree to have your photograph taken prior to treatment for use in tracking your progress? Y/N

I attest the above information is true to the best of my knowledge knowing my physician relies on this to provide safe and effective treatment.

Signature: _____ Date: _____