

Gynecological History:	
Last PAP	(mm/dd/yy)
PAP Results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
History of abnormal PAP smears?	<input type="checkbox"/> No <input type="checkbox"/> Yes If so, nature of diagnosis, treatment, and follow-up:
Last menstrual period	(mm/dd/yy) OR <input type="checkbox"/> Menopausal
Reason for Treatment	

Check if a condition, which may be a contraindication, is present:
<input type="checkbox"/> Vaginal or Pelvic area surgery within the last 12 months
<input type="checkbox"/> Implants or mesh in the treatment area
<input type="checkbox"/> History of genital herpes
<input type="checkbox"/> Unexplained vaginal bleeding
<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Pelvic infection
<input type="checkbox"/> Active malignancy or cancer treatment within the last five years
<input type="checkbox"/> Melanoma History
<input type="checkbox"/> Dysplastic nevi in the treatment zone
<input type="checkbox"/> Pelvic lymph node dissection or poor lymphatic drainage
<input type="checkbox"/> Significant illness such as diabetes, cardiac disease, autoimmune disease
<input type="checkbox"/> History of epidermal or dermal disorders involving collagen or microvasculature
<input type="checkbox"/> Active electrical implant in any region of the body
<input type="checkbox"/> Pregnancy or nursing
<input type="checkbox"/> Diseases of the immune system such as HIV, AIDS, or immunosuppressive medications
<input type="checkbox"/> Diseases which may be stimulated by light at the wavelengths used
<input type="checkbox"/> Use of anticoagulants or history of bleeding disorders
<input type="checkbox"/> Any active condition in the treatment area, such as open lacerations, abrasions or lesions, psoriasis, eczema, or rashes or any active lesion in the treatment area
<input type="checkbox"/> History of skin disorders, keloids, abnormal wound healing
<input type="checkbox"/> Surgical procedure in the treatment area within the last three months
<input type="checkbox"/> Tattoo in the treatment area
<input type="checkbox"/> History of Accutane use in the previous 6 months
<input type="checkbox"/> History of oral corticosteroid use in previous 6 months
<input type="checkbox"/> Excessively tanned skin in the treatment area from sun, sun-beds or tanning creams
Patient Signature: