Patient History | MonaLisa Touch

Name:	DOB:	Number of pregnancies:	Deliveries:
Date of your last menstrual cycle/onset of menopause?		Referral: Primary GYN and/or PCP	
Date of last pelvic exam/pap smear?			

	Yes	No	(*If "yes" please give full details, dates, treatment etc.*)
Have you ever had an abnormal pap smear?			
Do you have a history of, or think you currently may have, a vaginal, cervical or pelvic infection?			
Do you have a history genital herpes?			
Have you recently had any gynecological treatments or surgery?			
Do you have implanted mesh for stress urinary incontinence?			
Do you have a history of radiation therapy to the vaginal or colorectal tissue?			
Do you have a history of keloid formation or hypertrophic scarring?			
Are you pregnant, think you may be pregnant or are within 3 months postpartum?			
Are you using aspirin, Motrin or any blood thinning medication regularly?			
Do you have any chronic medical conditions?			
Do you have any type of immune deficiency? (eg. HIV or Hepatitis) or history of impaired wound healing?			
Do you have any allergies?			
Do you take any prescribed or non-prescribed medication or herbal remedies? (eg. St Johns wart)			

Patient Signature:	Print Name:	Date:
Practitioner Signature:	Print Name:	Date:

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