Nathan Eberle
DDS MD FACS
17160 Royal Palm Blvd. Suite 4
Weston, Florida 33326
954-507-4540

Medical History Form

Please answer all of the following questions, If it does not apply, please type N/A

List any & all medications & dosages; & supplements if any. If it does not apply, please type N/A *

List any diet/weight loss medications or supplements if any. If it does not apply, please type N/A *

Allergies: *

◯ Yes ◯ No

Disclose any allergies & reactions if any. If it does not apply, please type N/A *

Have you had any procedures in the past 12 months? *

◯ Yes ◯ No

Disclose any surgical history & complications if any. If it does not apply, please type N/A *

Do you have ANY current or chronic medical illnesses? *

◯ Yes ◯ No

Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness. If it does not apply, please type N/A

Do you have ANY current or chronic skin conditions? *

◯ Yes ◯ No

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

Are you currently under a doctor's care? *

◯ Yes ◯ No

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If so, for what reason?

Which body area/areas or condition would you like treated? Please list: *

Please answer all of the following questions: *

	Yes	No
Do you take/use ANY medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? *	○	○
Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? *	○	○
Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? *	○	○
Do you have ANY allergies to medications, foods, latex or other substances? *	○	○
Do you have a history of herpes I or II in the area to be treated? *	○	○
Do you have a history of keloid scarring or hypertrophic scar formation? *	○	○
Do you have a history of light induced seizures? *	○	○
Do you have any open sores or lesions? *	○	○
Do you have any history of radiation therapy in the area to be treated? *	○	○
In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? *	○	○
In the last three (3) months, have you used any of the following products: glycolic acid or otheralphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments? *	○	○
Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? *	○	○
Do you have or have you ever had any Botulinums, such as Jeuveau, Botox® or Dysport®? *	○	○
Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? *	○	○
Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months? *	○	○
Have you ever had a problem when having your blood drawn? *	○	○
Do you think that you sweat more than normal or are an excessive sweater? *	○	○
Do you have a history of fainting or passing out? *	○	○
Do you consider yourself to have an anxious or nervous personality? *	○	○
Have you been diagnosed with an anxiety disorder? *	○	○

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Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4 weeks? *	◯	◯
Have you used hydroquinone (HQ) in the last 6 months? *	◯	◯
IS THERE A FAMILY HISTORY OF UNEXPECTED DEATH(S) FOLLOWING GENERAL ANESTHESIA OR EXERCISE? *	◯	◯
IS THERE A FAMILY OR PERSONAL HISTORY OF MALIGNANT HYPERTHERMIA? *	◯	◯
IS THERE A FAMILY OR PERSONAL HISTORY OF A MUSCLE OR NEUROMUSCULAR DISORDER? *	◯	◯
IS THERE A FAMILY OR PERSONAL HISTORY OF HIGH TEMPERATURE FOLLOWING EXERCISE? *	◯	◯
IS THERE A FAMILY OR PERSONAL HISTORY OF MUSCLE SPASMS? *	◯	◯
IS THERE A FAMILY OR PERSONAL HISTORY OF DARK OR CHOCOLATE COLORED URINE? *	◯	◯
IS THERE A FAMILY OR PERSONAL HISTORY OF UNANTICIPATED FEVER IMMEDIATELY FOLLOWING ANESTHESIA OR EXERCISE *	◯	◯
Blood clot/DVT *	◯	◯
Chest Pain *	◯	◯
Seizures *	◯	◯
Pulmonary embolism *	◯	◯
Hypertension *	◯	◯
Migraines *	◯	◯
Bleeding disorder *	◯	◯
Heart disease/heart conditions *	◯	◯
Blockage of arteries *	◯	◯
Swelling (edema) *	◯	◯
Stroke *	◯	◯
Shortness of breath *	◯	◯
Thyroid disorder *	◯	◯
Hepatitis *	◯	◯
HIV/AIDS *	◯	◯
Obesity *	◯	◯
Thyroid Disease *	◯	◯
Pancreas Condition *	◯	◯
Medullary Thyroid Cancer *	◯	◯
Multiple Endocrine Neoplasia *	◯	◯

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For women:

	Yes	No
Are you or could you be pregnant?	◯	◯
Are menstrual periods regular?	◯	◯
Have you ever been diagnosed with Polycystic Ovarian Disorder?	◯	◯

05/22/2025 *

Tap here to sign

Bruise Easily *	◯	◯
Immune Deficiency *	◯	◯
Rheumatism *	◯	◯
Scarlett Fever *	◯	◯
Glaucoma *	◯	◯
Cold Sores *	◯	◯
Herpes *	◯	◯
Keloids *	◯	◯
Tuberculosis *	◯	◯
Auto Immune Disorder *	◯	◯
Psychiatric Condition *	◯	◯
Cancer *	◯	◯