MonaLisa Touch Medical History

Patient Name: _____ DOB: _____

History of vaginal, cervical or vulvar lesions that have not been evaluated? **Yes** **No**

Current herpes lesions or vaginitis symptoms? **Yes** **No**

History of herpes in past? **Yes** **No**

Pregnancy within the last three months? **Yes** **No**

History of radiation to the pelvis or colorectal area? **Yes** **No**

History of reconstructive pelvic surgery with mesh kits? **Yes** **No**

History of impaired wound healing or keloid formation? **Yes** **No**

Medical conditions/diagnoses/surgeries:

Current Medications:

Allergies: _____