DTS – Laser Contraindications

Patient Name:_____

DTS	YES	NO
Are you pregnant?		
Do you have osteoporosis?		
Do you have an abdominal herniation?		
Are you post-surgical? (at least 1 year after surgery) Type of surgery:		
Do you have cystocele/dropped bladder/prolapsed bladder?		
How much do you weigh?		
LASER		
Do you have or have ever had cancer? Type of cancer:		
Are you sensitive to light or on antibiotics that cause light sensitivity?		
Do you have a pacemaker?		

Patient signature:_____date:_____