Kindly fill out this Questionnaire to inform us of your medical history.

HIV ____

High Blood Pressure ____

Diabetes ____

Heart Disease ____

Pacemaker ____

Mitral Valve Prolapse ____

Kidney Disease ____

Liver Disease ____

Peptic Ulcers/gastritis ____

Hepatitis ____

Thyroid Disease ____

Hormone Problems ____

Bleeding Problems ____

Prosthetic joints ____

Lupus/Conn Tissue ds. ____

Hay Fever ____

Asthma ____

Skin Cancer ____

If yes please list type, date and face/body site

____

____

Do you smoke Yes No

Do you form excessive

scar tissue/keloids? Yes No

NAME____________________________________

Are you now pregnant or planning a pregnancy

in the near future? Yes No

Are you presently taking birth control pills?

Yes No

Do you have a Prescription Plan? Yes No

ANY ALLERGIC REACTION TO MEDICATION
Yes No

If yes please list______________________

____

Please list all medications you are presently

taking. ____________________________

____

____

Please list reason(s) for today's visit ______

____

____

Please remember to **schedule**

your full body exams

Are you interested in learning about

Our cosmetic services

Botox,/Dysport____ Facial Fillers____

Facials___ Peels___ Microderm___

Laser for veins___ scar___ wrinkles___ birthmarks___

Laser hair removal____Waxing____ *ask for details*

3/13