



MEDICAL SPA & LASER CENTER

Medical History

Patient Name: _____

List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins, and herbals):

1: _____ 2: _____ 3: _____
4: _____ 5: _____ 6: _____

List any allergies _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO	Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis' Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy, Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Do you have ANY skin disorders or active skin infections? YES/NO

Have you ever had skin cancer? YES / NO

Has anyone in your family had skin cancer? YES / NO

Do you have problems with healing YES / NO

Do you develop keloids (scars) after surgery YES / NO

Do you bleed easily or have any history of bleeding disorders? YES / NO

Do you develop skin rashes in reaction to Medications/Food/Environment? If yes, please list _____

Social History:

Do you drink alcohol? YES / NO If YES: Drinks per day: _____

Do you use IV drugs? YES / NO If YES, What? _____ How often? _____

Do you smoke? YES / NO If YES, how much: _____

Have you had or have you been exposed to HIV (AIDS)? YES / NO

Women - Are you pregnant? YES / NO Due Date: _____

Patient Signature

Print Name

Date

Reviewed By

Print Name

Date